CERTIFICATE OF NEED (CON) COMMISSION MEETING
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

TUESDAY, DECEMBER 9, 2003

3423 North Martin Luther King
MDCH Public Health Building #19
North Complex Baker-Olin West (BOW)
Lansing, Michigan
10:00AM

APPROVED TRANSCRIPT (MINUTES)

MEMBERS PRESENT:
Renee Turner-Bailey, Chairperson
Jack Smant, Vice Chairperson
Peter Ajluni, D.O.
Richard Breon
Bradley Cory
James K. Delaney (via conference call 11:45am-1:00pm and 1:50 –2:30pm)
Edward B. Goldman
Norma Hagenow
James Maitland
Michael Sandler, M.D.
Michael Young, D.O.

Department of Attorney General Staff Present:
Todd Cohan

Michigan Department of Community Health Staff Present:
William J. Hart, Jr.
Larry Horvath
Brenda Rogers
Jan Christensen

General Public Attendance:

Approximately 50 people in attendance.

MS.TURNER-BAILEY: Good morning. I'm going to call this meeting, December 9th meeting of the Certificate of Need Commission to order. I apologize for us starting a little bit late, but I was trying to accommodate the fact that I know there were various traffic issues and allow everyone to get here. I think we have accomplished that. At this point I would like to just take a quick review of the agenda and ask are there any comments, questions, suggestions for changes? Brenda? Sorry.

MS.ROGERS: What I would like to add to the agenda under public comment on the backside of your agenda is an item B, and what that would be is a (inaudible) presentation from Carol Halsey from our staff.

MS.TURNER-BAILEY: Okay. Are there any other suggestions for changes in the agenda? I would like to say that I'm going to ask for your indulgence on a little bit of flexibility as we move through the agenda. We do have one commissioner that is going to be available by phone, and he has a relatively strict time limit, so I'm going to try to accommodate him relative to some of the meatier items on the agenda. Hearing no other suggestions for changes, is there a motion to accept the agenda as amended?

MR.MAITLAND: Maitland moves to accept the agenda as suggested.

DR.SANDLER: Support.

MS.TURNER-BAILEY: It' s been moved by Commissioner Maitland and supported by Commissioner Sandler that we accept the agenda as amended. All those in favor signify by saying aye. Opposed? At this point it would be appropriate to hear declarations of conflict of interest. Dr. Sandler?

DR.SANDLER: Yes. There is the potential conflict of interest under the following: I work in a hospital that actually does have beds, so bed methodology; I am a radiologist in an institution that has, I believe, seven CT units and we will be getting a PET scanner; and an institution that does have a lithotripsy, although I personally have nothing to do with that; and an institution that has radiation oncologist services. And again, I don' t believe I am in conflict of any of these, I only read radiographs and will not benefit financially from any of these, and I don' t believe there is any conflict of interest, but I do wish to point that out.
The second thing, which is an update that it is suggested that Commissioner Sandler, and Commissioner Hagenow as well, may wish to discuss this with the State Ethics Committee. We are pursuing that, but this has not been the easiest pursuit. They could not make the November meeting. We had a very short time frame. Appearance is supposed to be in January. I have asked Mr. Styka to get the date as soon as possible so I can accommodate this. Mr. Dugan is a lawyer, but he is going to be the head of DMC, and Dr. Sandler is a doctor but he has to go to jury duty in January. And I have a short trip out of town. But I have tried to pursue this. (Inaudible) -- I am pursuing that.

MS.TURNER-BAILEY: Okay, thank you. Just to support what you said, we have sent an official letter to the ethics board asking for their opinion relative to conflicts of interest on certain areas of issues. We are waiting for the schedule of the board and the schedule of the commissioners to come together. And hopefully that will be relatively soon.

DR.SANDLER: I will make a comment. Although it is not mandatory, it is customary for the person who is -- (inaudible) -- present to explain the situation to the ethics committee so they can (inaudible). I want to apologize to my fellow commissioners because of the commitment --(inaudible).

MS.TURNER-BAILEY: Okay. Any other discussion relative to conflicts of interest? Questions? The agenda item 4, review of minutes of the October 7th meeting. Are there any changes?

MR.MAITLAND: I wasn't at the meeting, but I see on the second to last page Dr. Sandler said I abstained on the vote. I have done a lot of things in my life, but I have never abstained on a vote. I think you meant I was absent, probably.

DR.SANDLER: I would have to go to that point in the minutes.

MR.MAITLAND: Page 33 in the minutes.

DR.SANDLER: I have been accused of doing some strange things.

MR.MAITLAND: I wouldn' t put it past you.

MS.TURNER-BAILEY: I guess I should ask this question: Since the minutes were by the transcript, we can' t change the word that he said, but we should make some note that Mr. Maitland did not actually abstain from the vote, that he actually was absent from the meeting. So I think probably we should work that out.

DR.SANDLER: I probably was misquoted, but thank you.

MS.TURNER-BAILEY: Okay, are there any other additions, corrections to the minutes?

MR.MAITLAND: Well, Mr. Cory' s name is spelled wrong. C-O-R-Y.

MS.TURNER-BAILEY: Great. So with those two, that one change and that one amendment to the minutes, I will accept a motion to accept with those two changes.

MR.CORY: So move.

MS.TURNER-BAILEY: Moved by Commission Cory, support by Commissioner Breon. All those in favor signify by saying aye. Opposed?

As you can see under the agenda item five, there are many, many items, and these are the items that are taking into account some of the statutory changes and other kind of changes that we have to make to the standards. I'm going to ask Brenda to walk us through those changes. And then at that time, I'm going to give you fair warning, we are told we cannot vote on these as a package, we have to go through each one and approve them. So we have a little bit of work ahead of us. Brenda?

MS.ROGERS: I'm not going to go through every single change because for the most part it is the same language that we discussed at the last commission meeting. However, for each of the standards we are making or suggesting an amendment to each of these set of standards, and that is adding in the new definition of rural based on the statute. And so that would be an amendment. It would not require another public hearing in talking to our counsel. So just to let you know that.

In addition, we are going to have some presentation today for a couple of other proposed amendments to these standards that will be tied in to the rule definition. So I think we may have a position for this.
What we are going to be suggesting is -- I passed out some information to you just a few minutes ago -- is adding in, if you want to take a look at this sheet here, adding in two more additional definitions to each of these standards. And those definitions would be metropolitan statistical area county and micropolitan statistical area county. And those are a break-off of the rural definition as defined in the statute. So there is a legal basis for the definition with some, from the federal government. And tying into that what we believe this will allow is to keep the essence of the current standard intact.

So what we would be doing is anyplace in each of those standards where it references the rural definition or rural county, it would now say rural or micropolitan statistical area county. And where it says non-rural in those standards it would now be metropolitan statistical area counties. So essentially all of our previous rural counties would still be able to fall under the same requirement that the standards were set up for. Again, there will be some testimony in regard to that today. So if you have any questions.

Also broken out there's three separate lists here, and these would be added to each of the standards as an appendix at the back of the standard, and it would identify those that are rural Michigan counties, micropolitan statistical area counties, and metropolitan statistical area counties. And I think this would also in the long term -- right now we essentially deal with rural and non-rural, but in the long term this would give you three areas that you could look at if you wanted to. So you have another breakout.

Do we have any questions on that? I would be happy to try and answer those. So those are the two major changes to the language that was presented at the last meeting and that the Commission agreed to.

MS.TURNER-BAILEY: Okay, are there any questions for Brenda?. Commissioner Cory?

MR.CORY: I notice that one of the counties, for example, in the micropolitan statistical area is Chippewa. And -- (inaudible) -- and they are not listed under the rural Michigan.

MS.ROGERS: What will happen is in each standard, okay, let's say, for example, MRI has the rural definition in there. So anyplace that there is a rural exception, so to speak, that exception now will be both applicable to rural and micropolitan. So we will have to add that in to that portion of the standard.

MR.CORY: So sort of a circle around the whole thing.

MS.ROGERS: Yes.

MR.CORY: Thank you.

MS.TURNER-BAILEY: Any other questions? Any discussion? I have Amy Barkholz.

MS.BARKHOLZ: Hi. Thanks. I' m Amy Barkholz from the Michigan Health and Hospital Association. I just want to -- there. Is that a little bit better? Sorry about that. Amy Barkholz from the Michigan Health and Hospital Association. I just want to actually add to the comments that Brenda made just to sort of fill in some of the details for why we have these three types of definitions now.

You might remember at the September meeting when the department raised the sort of technical issue of making all of the standards comply with the new changes in the CON law, one of those technical statutory changes was to incorporate this new definition of the rural. And when this was put into the statute last year, it really didn' t raise the red flags that it probably should have for all of us, because what that new definition did, it took terms that are in the new 2000 census to define rural. And it said that a rural county is any county that is not a micropolitan statistical area or a metropolitan statistical area.

The problem for us with our CON standards is nobody intended to really shake up things as much as this statutory change did. It took 25 counties, many of which we think of as very rural -- as you pointed out, Keweenaw and Houghton, many in the U.P., many in northern Michigan, and termed them micropolitan statistical area so they would no longer qualify for the same provisions as rural counties in all of our standards.

When we raised this issue in September you all agreed to let us talk with the department and see if we could find a solution to this, but still we need to move forward, obviously, and make the changes in the CON standards to make them consistent with the law that we passed. Well, we think we have come up with a very good solution that will be very easy that will allow that to happen and will really create the status quo, the same intent that we wanted to create all along.

And what all that means that we did is we took, we defined micropolitan statistical area county and metropolitan statistical area county from the definitions that' s in our CON statute. And we just add that definition into all the standards that now use the term rural and non-rural. And then wherever it says rural, we will add rural or micropolitan statistical area, and wherever it says non-rural we will add metropolitan statistical area. Those terms will now be defined and it will pretty much mean things are the same. The micropolitan and rural areas will be subject to the provisions they were always subject to, and the non-rural areas will be subject to the same provisions because they will be called metropolitan statistical area.

MR.CORY: One question. Is there any difference between "rural or" as contrasted with "rural and"?

MS.BARKHOLZ: No. We need to use the word "or," because under the new definition you cannot be rural and micropolitan, you have to be one or the other. Keweenaw is now no longer rural according to the statute, the law that we passed a year ago. That' s the big problem. So since Keweenaw is no longer rural according to that law, and we can' t change the law, the legislature has to do that, what we had to do is say you could be rural or micropolitan, and that will make sure that Keweenaw, Houghton, the folks in northern lower peninsula that have been always considered rural will continue to be subject to the same provisions as the rural counties.

MR.CORY: Thank you.

MS.TURNER-BAILEY: Any further questions?

MS.BARKHOLZ: One point that I would add is actually wanting to thank the department. Because we talked about this and came up with the solution in very last minute notice and they incorporated all of this language into these new standards. The other point is I have some letters that were passed out. One is from Portage Health System up in Houghton supporting these proposed changes, and another letter is from the MHA' s North Central Hospital Council. Those are the hospitals in the northern lower peninsula. There are at least seven counties that are affected, and they support the changes. And I know the Center for Rural Health, John Barnes is sitting in the audience and he was part of these discussions and he is also very supportive of these proposed changes. Thanks.

MS.TURNER-BAILEY: Okay, any more questions? Thank you. So we have two major changes from the language that we sent for public comment before you saying we can make those changes if the Commission agrees without sending the language back for public comment.

MS.ROGERS: The guidance I was given is the definition of rural can definitely be sent forward without another public hearing. But adding the other two definitions and the other changes regarding micropolitan and metropolitan is a substantial enough change that it would have to, unfortunately, have to go out for another public hearing. Now, we do have some dates in January where we have some rooms available, so I think we can get that scheduled fairly quickly. But that was the information I was given.

MS.TURNER-BAILEY: Okay, is there any discussion?

MR.GOLDMAN: Just one quick question.

MS.TURNER-BAILEY: Yes.

MR.GOLDMAN: Brenda, these changes would then put the standards in accordance with the changes that the legislature required that we make. So it would include the Title 19 issues, the rural, metropolitan/micropolitan. Are there any other technical changes that we need to make at the same time as long as these have to go out for a public hearing again?

MS.ROGERS: Not that I can think of right offhand. We could take a quick look at that before we would send it to public hearing, but I don't believe there are. I believe this incorporates all of them.

MR.GOLDMAN: I looked at the statute; I believe that is correct. But as long as we are doing it, it would be worthwhile double-checking that. And we should look and make sure we have got all the Title 19 language that we need to make it clear that you have to be a participant in Medicaid, full participant. So as long as we are thinking of that, that would be useful. Thank you.

MS.TURNER-BAILEY: Beginning with air ambulance services, is there a motion? I think we should come up with one for all of them and we can use that.

MR.BREON: Excuse me. Could I just have a comment?

MS.TURNER-BAILEY: Oh, sure.

MR.BREON: Brenda, the question about participation in Title 19, is there any more clarity there other than just participation? Does that mean if you see one patient, that's participation? Or is there any relationship to the amount of patients to the population or anything of that nature? It's kind of vague the way it's written.

MS.ROGERS: We simply incorporated what was in the statute. So it is very basic, very general. But that's what was incorporated. If the Commission feels there needs to be more than that, that's certainly something that can be looked at. But that's what we based it on, was the statute.

MR.BREON: So according to the statute, if you saw one patient, that's participation. I don't think that was the intent.

MS.ROGERS: Larry can correct me if I'm wrong, but I think part of that is going to be an internal process as far as how we actually monitor that. Because in the (inaudible) requirements for each of those standards they have to, I think it's every, once a year they have to be showing that they are in compliance. How we are going to handle that internally I can't answer that at this point. But I believe that's going to be part of the internal process.

MS.TURNER-BAILEY: Any other questions? Any motion? Air ambulance services.

DR.AJLUNI: (inaudible).

MS.TURNER-BAILEY: And your motion is to correct the language with the suggested changes? And send it to public comment? Okay, there has been a motion to accept the changes to the language on air ambulance services suggested today and to send that language to public comment. Is there support?
UNIDENTIFIED SPEAKER: Support.

MS.TURNER-BAILEY: It has been supported. All those in favor signify by saying aye. (Verbal vote.) Bone marrow transplantation.

MS.ROGERS: Renee, just for the court reporter' s benefit could you say who made the motion and who seconded by name?

DR.AJLUNI: Motion made by Dr. Ajluni.

DR.YOUNG: Support by Mike Young.

MS.TURNER-BAILEY: Thank you. Bone Marrow Transplantation.

MR.GOLDMAN: So moved.

MS.TURNER-BAILEY: Commissioner Goldman.

MR.MAITLAND: Support by Maitland.

MS.TURNER-BAILEY: Support by Maitland. All those in favor? Do we have to repeat the motion every time?

MS.ROGERS: No.

MS.TURNER-BAILEY: Okay. All those in favor, signify by saying aye. (verbal vote.) Opposed? Cardiac cath?

MR.MAITLAND: Moved.

DR.SANDLER: Second.

MS.TURNER-BAILEY: I' m sorry, who second? Commissioner Sandler. All those in favor signify by saying aye. (verbal vote.) Heart, lung, liver transplant services.

MS.Hagenow: Hagenow moves.

MS.TURNER-BAILEY: Motion by Commissioner Hagenow, support by Dr. Young. All those in favor, signify by saying aye. (verbal vote.) Neonatal -- I' m sorry MRI.

MR.HORWITZ: Madam Chairperson?

MS.TURNER-BAILEY: Yes.

MR.HORWITZ: I just wanted to comment on this.

MS.TURNER-BAILEY: Oh, okay.

MR.HORWITZ: This is a generic comment.

MR.NASH: Please state your name.

MR.HORWITZ: Larry Horwitz, Economic Alliance. I printed my name, I passed in a card. The statute goes beyond just participation. It says in evaluating applications it shall be a distinct criterion weighted as very important, okay? And determine the degree to which the application meets this criteria based on the extent of the participation in the Medicaid program. So just doing one is going to be different than doing more. It' s not clear if one means a dollar, a day, a patient, a discharge/admission, but it has to be done. And that means it is going to be the burden on this Commission, now that you have done this (inaudible) thing that you say you are doing that, to put some flesh on the bones in a substantive fashion on each of these standards deciding what the comparative review points are. This is what it says when you do a comparative review. So if we have more

people applying for PETS than are available or more beds or something else, you are going to need to have in the CON standards comparative review points. You already have that, for example, in nursing home standards and so forth.

If you look at the nursing home standard, you get more points to win the nursing home bed if you have more participation in Medicaid than someone else. So you are going to have to decide as these standards come before you how you want to weigh it, how many points. Do you want to give 30 percent of the points for Medicaid? 40 percent? How much you want to give for uncompensated care, presuming it is a related topic, and how you measure them.

So the department is not going to be able to do it by itself, although it says the department shall do it, because under the CON statute the department is guided by how it evaluates applications based on the criteria passed by you. So I presume that the standard of participation of Medicaid you might make a judgment should be differently constructed for an acute care patient, getting an acute care bed than being awarded a PET machine. To me, logically there would have to be some difference.

That is just a generic comment. I think it's fine and great and noble that we are putting this all in here, but it's sort of a pro forma compliance and doesn't really take care of the nuts and bolts of how to decide if you have applications for 222 beds and there is a need for 118, how do I give how many points to whom and how do I measure it. And I think that's one of the things that the ad hoc on the hospital bed standards has as part of its report that says needs to be done for hospital beds. We have it for the other kinds of beds, psychiatric and nursing homes, but that needs to be done for acute care. Thank you.

MS.TURNER-BAILEY: Are there any questions? Thank you. Is there a motion for the language changes and send it to public comment for MRI?

MS.HAGENOW: Move.

MS.TURNER-BAILEY: It has been moved by Hagenow, support --

DR.SANDLER: Support.

MS.TURNER-BAILER: -- by Sandler. All those in favor signify by saying aye. (verbal vote.) Neonatal Intensive care services and beds. Is there a motion?

MR.GOLDMAN: So moved.

MS.TURNER-BAILEY: So moved by Commissioner Goldman.

DR.YOUNG: Support.

MS.TURNER-BAILEY: Support by Commissioner Young. All those in favor signify by saying aye. (verbal vote) Opposed? Nursing home and hospital long-term care bed units.

MR.MAITLAND: Maitland moves.

MS.TURNER-BAILEY: Ajluni seconds. All those in favor signify by saying aye. (verbal vote) Opposed? Pancreas transplant services. I'm sorry, open heart surgery services.

MR.GOLDMAN: Goldman moves.

MS.TURNER-BAILEY: Moved by Goldman. Support by young. All those in favor signify by saying aye. (verbal vote) Opposed? Pancreas transplantation services.

MR.MAITLAND: Maitland moves.

MS.TURNER-BAILEY: Moved by Maitland.

MR.BREON: Support.

MS.TURNER-BAILEY: Supported by Breon. All those in favor signify by saying aye. (verbal vote) Opposed? Motion carries. PET scanner services.

DR.Sandler: Sandler moves.

MS.TURNER-BAILEY: Sandler moves. That's appropriate. I'm sorry, supported by Commissioner Young. All those in favor signify by saying aye. (verbal vote) Opposed? Psychiatric beds and services.

MS.HAGENOW: Hagenow moves.

MS.TURNER-BAILEY: Hagenow moves. Supported by --

MR.GOLDMAN: Support.

MS.TURNER-BAILEY: -- Goldman. All those in favor signify by saying aye. (verbal vote) Motion carries. Thank you very much for your patience. I believe we are going to send all those out for public comment. They can all go out for public comment all in one meeting and we will get those back at the March meeting for final action. CT services.

MS.ROGERS: I'm not going to review the entire set of language. It is basically as presented at the last Commission meeting. However, we would again take the CT language, recommend the same amendment that you did approve for the previous standards, and that would be adding the rural definition based on statute and adding the terms micropolitan and metropolitan statistical areas as well and make those appropriate changes. And again, it would have to go out for another public hearing, unfortunately.

MS.TURNER-BAILEY: Can we put that in with the other language? Can we do that all in one? Is there any discussion on the CT change?

MR.GOLDMAN: There is one question. Given what Larry Horwitz just commented about, do we want to be more specific in terms of participation for this specific standard? For the CT standard.

MS.ROGERS: Under the CT standards there is no comparative review, so that would be up to the Commission. So certainly if there was comparative review involved and you wanted to add more definitive language, there wouldn't be a problem with that. And even though there is not comparative review, the commission still (inaudible).

MS.TURNER-BAILEY: Commissioner Sandler?

DR.SANDLER: The fact that there is no comparative review, either you qualify under this criteria or you do not qualify under this criteria. As long as you make a stipulation that you have to accept Medicaid patients, I don't believe it is necessary to change the standard any more than that. Thank you.

MS.TURNER-BAILEY: Any other discussion? Yes, Commissioner Breon?

MR.BREON: Yes. I don't know if I agree with that. I can understand that point of view, but you could also have a CT scan and see two Medicaid patients and comply with the letter of the law as it's written. So I think there is a problem with that. I think there ought to be some specified connection to the amount of Medicaid in a certain population or something; otherwise, the language is meaningless and doesn't have any teeth other than just participate. If you don't describe what that means, I'm not sure it means much.

DR.SANDLER: Can I make a comment that perhaps will clarify?

MS.TURNER-BAILEY: Commissioner Sandler.

DR.SANDLER: I don't think you can make a comment in terms of number, because now you are going to be (inaudible) location and not be in some circumstances. You can make a stipulation that Medicaid patients have to be treated with equal access to all other patients.

MR.BREON: But I think in the real world it doesn't actually happen that way. You say it is true, and I understand that. I'm not looking for a specific number, per se, but just I think it's so vague I'm not sure it means a whole lot. And even though you have equal access, it doesn't exactly happen that way. People don't necessarily flow, you have to look at who directs the patient and how people get there. And all the ones that have money go someplace, those that are on Medicaid and indigent care go somewhere else. So I don't know if there is a way of putting something more specific in there. I certainly understand all the arguments and understand the letter of the law, it's just that I'm not sure it has a lot of teeth.

MS.TURNER-BAILEY: Commissioner Hagenow?

MS.HAGENOW: I'm -- whether I'm the only one that is sort of lost in this. Where in this CT standard is the wording that we are saying we need to change? Potentially. I'm just trying to get -- where is this Medicaid issue?

MS.ROGERS: It is under Section 10. And that's the part where all applicants must provide verification of participation.

MS.HAGENOW: And so if we had more -- if that's saying that if you make an application to be able to put in a CT scan that you must verify that you have Medicaid participation, what I heard Larry Horwitz say is that it's when you have a comparison of more than one that you would have to differentiate to put teeth into it.

MS.ROGERS: Under those standards that are subject to comparative review, they have point systems, and I believe that's what Larry was referring to. So in those cases, then you are going to want to put a specific number of points to that criteria. But in these standards that don't have comparative review, I do not believe that that's (inaudible).

MS.HAGENOW: So then the point comes should we require that it's not just participation to be able to achieve, it's not a comparison here, it's just to be able to meet approval for what you are requesting, that you are not just participating but that you are participating at a level that is commiserate with your proportionality of Medicaid or something of that nature.

MS.ROGERS: Right. And I think at this point, again, it is going to be part of the internal process, what will we accept as that verification.

DR.SANDLER: I have some concern, however, about micromanaging the situation. Impetus for the CT change, one of them was so rural hospitals, or the new term for something similar to a rural hospital, would have the opportunity to have CT scanners because of the urgent nature of many of the indications received; such as trauma, for example. How many Medicaids that the hospital in Kalkaska has I'm not certain it relevant to this point. The point is they will accept, they have to accept all Medicaid patients on an equal basis. And I'm a little concerned about micromanaging this because it certainly was not -- as long as you make it clear that you are not discriminating against Medicaid patients, that you accept Medicaid patients, I think that accomplishes, since there is no comparative review here, what we have asked.

MR.BREON: If I could just comment. I don't think the issue is in Kalkaska. I don't think in a rural hospital the issue is Medicaid participation. I think the issue is when a group of physicians or somebody else right next door to your organization puts up a CT scan and they don't have to participate with Medicaid, or, if they do, there is no way of knowing whether one, two or three members of Medicaid participants meets the letter of the law. That's the issue.

The issue is not a rural issue to me, it's in urban areas where you have competing entities. And we have several of those already in place. But I think if you're going to have a level playing field, which is what we're talking about here, then you ought to have some language in here that indicates, if you are going to participate in Medicaid, it ought to be in some proportionate number of Medicaid participants in that area. As Commissioner Hagenow mentioned.

MR.HORWITZ: Madam Chairperson?

MS.TURNER-BAILEY: Yes.

MR.HORWITZ: I just want to make sure it is clear. The statute --

MS.TURNER-BAILEY: This is Larry Horwitz speaking.

MR.HORWITZ: I' m sorry. Larry Horwitz, Economic Alliance. And Stan said I didn t have to turn in a second card.

MS.TURNER-BAILEY: Okay. Stan' s the boss.

MR.HORWITZ: For anything you deem under comparative review you have a statutory obligation, pursuant to last year' s law, to weigh it significantly, right? And I don' t think the department can do that by itself. It can' t just decide rules, it has to have some criteria set down in writing. And that' s where they get it from, is you, the Commission.

Two. For a -- so to have -- so you have to do that there. Okay. You have to decide how important it is and how much you measure it. And maybe you do it based on your catchment area has -- 20 percent of the people in your catchment area are Medicaid participants and you have to have at least halfway there, 10 percent to which you have delivered that particular service. You can do it that way or days or beds or dollar or something.

In an individual case, for example, CT, you are not bound by the statutory language. You have in your discretion the ability -- so to comply with Public Act 619 you didn' t have to put Medicaid participation in this standard, because CT is not a comparative review standard. That' s your choice. The Department' s recommending you do that. Participation is something that is already a defined term. Medicaid participation is a defined term by the Department of Community Health itself in its Medicaid subdivision, and there is a very clear categorization of who is a Medicaid participant and who is not. So there is no one over in the CON division who is going to be able to say is this good enough participation or is it not good enough participation. They supply to you a piece of paper that says, I got from the Medicaid branch over here that I' m a participant, which merely means I' m willing to take Medicaid patients and take in full the money that the state will pay me and won' t balance bill is what it says. It' s up to you to exercise your judgment as to whether or not you want to make a requirement for someone to get a CT to do more than just say if a Medicaid patient finds his way to my door, I will take him. Right? Do you want to do that or not? And that' s the policy question you need to identify.

You know, we used to have language in some of the standards that says you can' t discriminate against people on the source of payment. In other words, you can' t treat them any differently if they are a charity case, a full charges case, or a Blues case or a Medicaid case. Do you want to make it somewhat tougher? I take it Mr. Breon is inclined to think we should at least explore that. If that' s what you need to do, I don' t think you need to do that today, but what I' m saying is that that is something I think you are going to want to make some prudential judgments on and potentially do it differently in CT than you do it in some other area. So comparative review is legally required, you have to do it; individual review is up to your judgment.

MS.TURNER-BAILEY: Are there any other questions or comments? Any suggestions for changing the language of the standards today? Is that what you are thinking of?

MR.BREON: Well, no, I don' t have the exact language that I would like to see, but I think we ought to at least try to incorporate that. I don' t want to minimize the availability of CT to rural areas or even to anyone else for that matter. I just think if you are going to put something like this in this legislation here you have to at least have it on a level playing field. So I don' t have the answer, but I certainly think it needs more discussion.

MR.CORY: I just have one comment. I think that from my perspective an agreement to participate in Medicaid is sufficient. You start defining numbers or percentages and I think that that opens up a bucket of worms.

DR.SANDLER: To address Commissioner Breon' s point, I' m certainly not opposed to adding something about the discrimination issue, there will be no discrimination on the basis of insurance. That' s fine with me. I think

that's the way the world should work. I'm a little concerned about trying to add specific language and hold up the standard. I mean, allow these hospitals that need these CT scanners ASAP. That was my concern.

MS.TURNER-BAILEY: Commissioner Hagenow?

MS.HAGENOW: I'm just bothered by some of the things that Commissioner Breon said in terms of competition drives people to say I'm participating and, so therefore, I'm not discriminating, but in reality the kind of niche in and out CTs are not going to have the Medicaid population while a public hospital, for instance, would get a whole lot of them. So there is something there that seems to me, you know, we need to explore. But I'm also very bothered by the fact that we have come to micromanaging things. So I would think that maybe we should go forward with it but ask for a review of possible language or something that we could get it to a point of further understanding, knowing what our purpose is, is to not have people cream off and just say, well, I am participating, but they are not doing anything.

DR.SANDLER: Perhaps a compromise would be to pass the standard with a comment about participation without any discrimination, and if Commissioner Breon has some specific language, we can take that up at the March meeting and not hold up the standards. I would be delighted -- (inaudible)

MS.TURNER-BAILEY: And it looks like we are going to make enough changes to the language today that we need to go back out for public comment anyway, so if there is something in particular we want to get some language together and put in there, this will be the time to do it and have it come up for the public comment. And we will be probably taking final action in March. Commissioner Hagenow?

MS.HAGENOW: And I would say that once we have determined that language, it would be true in these other definitions as we --

MS.TURNER-BAILEY: Good point.

MS.HAGENOW: So the work wouldn't be lost in terms of a very broad approach to every standard that we come along to.

MR.BREON: I support that.

MR.MAITLAND: When Larry spoke earlier, didn't he seem to indicate that there was a definition for participation in the federal standards or law? You were reading something.

MR.HORWITZ: No, it's not in this book, but there is a definition that the Community Health Department has. There is something that -- whatever under the reorganization you now call the old medical services administration where any entity, in order to get Medicaid money, whether it's a CT facility or a hospital, has to enter into an agreement with the state, which is called a participation agreement. And it sets forth what you have got to do. So either you have that participation agreement or you don't have that participation agreement.

MR.GOLDMAN: There's really two parts. Part one is if you want to participate, you give up the right to balance bill patients. That's what a participation agreement is all about. Part two, the part that I'm concerned about is other than comparative review, I think it is useful to have a standard in all of these that says that there needs to be participation, because I'm worried about the skimming problem. And the other question is, do we just say participation or do we have to think more critically about what participation means, either along the lines Larry Horwitz is talking about, a percentage of the population, or some other standard. I don't know what that standard is off the top of my head, but as long as we have the opportunity to have public hearing, what I'm suggesting is soliciting public hearing comments on that issue so at the next commission meeting we can think about whether it makes sense to say something other than have a participation agreement with the state. There may be something sensible to say, I don't know what that is off the top of my head. If there is, fine. If it turns out to look like too much micromanagement, that would be useful to know as well.

MS.TURNER-BAILEY: Well, I guess one of my questions would be -- I'm sorry, I called on myself. One of my questions would be what is the definition? What does it say today? If it is something we know what that is, it

would raise all our comfort levels. So maybe if we can ask the department to give us that information, and we would have that to work with, it may solve our problem without us adding anything else.
Commissioner Maitland?

MR.MAITLAND: That's where I was heading. And then just put it under the definitions, the definitions of participation under Title 9 or whatever this, is this, and we can do that for all of them and it wouldn't be part of the text but the definition of participation. That's why I asked that question. So I agree with you.

MS.TURNER-BAILEY: Any other questions or comments?

DR.AJLUNI: Just one. I have no difficulty with nondiscriminatory language, as Dr. Sandler pointed out, but first you have to come up with some language, and next we have to monitor what that language means as it relates to skimming issues, and then we have got to find a method of enforcing it. It would seem to me that this whole thing would be very difficult. First you have to get the language, then we have to monitor whether the skimming place is performing or not, and then we have to figure out some way to enforce the statute. I would be just for nondiscriminatory language as Dr. Sandler indicated.

MS.TURNER-BAILEY: Is there a way that we can ask for some draft nondiscrimination language as well as the current definition of Medicaid participation and have that available for us for making a decision when we take final action, this language? Or even prior to public hearing.

MR.HORWITZ: Madam Chairperson, you have already done it. Every standard has the nondiscrimination language in it. If you look on page 8 of this standard. This dates back from the 1989 revision. I don't think it has much teeth, but it sounds nice. Line 387. 385. The applicant, to assure that the CT scanner will be utilized by all segments of the Michigan population shall, A -- I'll wait until you catch up with me. This is in every standard I have ever seen. Not deny CT scanner services to any individual based on ability to pay -- that meant poor people, no pay -- or source of payment. And that was designed, that has often been called the nondiscrimination clause.

Then the implementation, the sort of monitoring of that is down on 393. It is line 390. Maintain -- the applicant shall maintain information by payor and non-paying source to indicate the volume of care from each source provided annually. So you have to figure out what's your bad debt, uncompensated care and so forth. And the -- (inaudible)-- as administered by the department, including information on the volume of care provided, from all payor sources. That was put in there in 1989 and the implementation of this new part, 222, and to my knowledge it has been a dead letter on the standards ever since. I can't recall a time that anybody from the department has come in to say, yo, commissioner/legislator, did you know that the participation level in, you know, that the, this is how much these following places get from no pay, bad debt, indigent care, et cetera, et cetera?

So in terms of having nice, pleasant sounding language, you have got in here a nondiscrimination clause. You have got in here that you will participate. The statutory, the definition Medicaid controls here. The question is do you want it to mean something more than nice words. But for nice words, you have already got them.

MS.TURNER-BAILEY: Commissioner Sandler.

DR.SANDLER: I would like to call the question. And the question is the passing of this standard as written with the nondiscrimination clause. And we thank Mr. Horwitz for enlightening us on this.

MS.TURNER-BAILEY: I guess, I know we can't have discussion, so I don't know what we are going to do. Because we haven't added the rural and the micropolitan language, and we can't pass the language if we pass that, that language is out. If we pass this language as it is written today, that language will not be in it.

MR.MAITLAND: I thought the motion already included that.

MS.TURNER-BAILEY: Who made the motion?

DR.SANDLER: I would like to call the motion -- call the question.

MR.MAITLAND: Support.

MS.TURNER-BAILEY: Okay, support. All those in favor signify -- I'm sorry, we are going to do our hand raising at this point. Raise your hand.

MS.HAGENOW: What are we voting on?

MS.ROGERS: Could I just clarify Dr. Sandler's motion? Is your motion to accept the language as presented today with the amendments for rural and the micropolitan and metropolitan statistical areas, or is it just language without the amendment?

MS.TURNER-BAILEY: We have to vote on calling the question, right?

MR.MAITLAND: Well, I withdraw my support if it doesn't include the language on--

DR.SANDLER: Commissioner Maitland, not so fast here.

MS.TURNER-BAILEY: I tried to clarify.

DR.SANDLER: My motion only ends the discussion. It does not specifically address the point you are making.

MR.MAITLAND: If we end discussion, then we have to vote on the motion which we have to clarify. Otherwise I'm not--

DR.SANDLER: Correct.

MR.MAITLAND: Did you include the definitions for rural?

DR.SANDLER: Yes.

MR.MAITLAND: I thought you did, and I still support it.

DR.SANDLER: But my motion is not a prejudicial vote for or against it, it is simply to call the motion because my wife told me to be home by midnight.

MS.TURNER-BAILEY: Okay, my understanding is we have to agree to call the question.

DR.SANDLER: Yes. You need a two-thirds vote.

MS.TURNER-BAILEY: Okay, all those in favor -- and has there been support to call the question?

MR.MAITLAND: Supported.

MS.TURNER-BAILEY: All those in favor, raise your right hand. Unanimous that we call the question. Now, to the motion on the CT language. There hasn't been a motion.

MR.MAITLAND: Yes, there has.

MS.TURNER-BAILEY: Who made it? We need a motion on the CT language.

DR.SANDLER: I propose the scanner as written with the incorporation of both the rural and micropolitan language as added to it.

MR.MAITLAND: Support.

MS.TURNER-BAILEY: Okay, it's been proposed by Commissioner Sandler, supported by Commissioner Maitland. Any discussion? All those in favor raise your right hand. Seven. Opposed? Confused?

MR.BREON: Can you add that as one?

MS.HAGENOW: Yeah, because I don't- I mean, if we are saying that we are now voting on basically the definition that we voted on the other procedures, and/or are we also voting for the revised standards and nothing to be done further relative to Medicaid and -- (inaudible). Is that it? I mean, one, two, three.

MS.TURNER-BAILEY: I would ask Dr. Sandler to clarify his motion.

DR.SANDLER: We are voting on the standard in front of us but to incorporate rural and micropolitan definitions as previously discussed. And it would include the language of Medicaid participation.
To further answer your question, if Commissioner Breon or Commissioner Hagenow or whoever feels this is not sufficient and -- (inaudible) -- bring it back on specific language at a future time to amend this.
My concern, let's move off the dime on important CT scans. It doesn't mean you can't change future language.

MS.TURNER-BAILEY: And the clarification I would like to again make is, because we are making the substantive change of adding the new definitions relative to micropolitan and rural, this has to go out for public comment again. We are going to take it, put it in with all those other bits of language that have to go out for public comment, which means that will happen in January, which means we will be taking final action on this language in March. That will be an opportunity -- I have already asked the department to give us the definition of Medicaid participation so we can see that. And if we feel that that is sufficient, we don't really need to do anything else. If not, we can add something at that time.

DR.SANDLER: There still would be an opportunity, but at least we would move forward.

MS.TURNER-BAILEY: Right. So the vote was seven --

MR.BREON: No, support.

MS.TURNER-BAILEY: Okay, unanimous vote. A couple of late votes. Okay, thank you.

MS.HAGENOW: The important point to me is that I would like to know whether there are people who are not following through on this. And so if we get the clarification of what the standard is from the community of health department about participation and what that means, then we could do -- I imagine we could ask for some review just to say are people pulling things on this; that is, leaving public hospitals with the bag.

MS.TURNER-BAILEY: Good point. The next agenda item is hospital beds, sub-area, and bed need methodology. We are going to ask for a report from Jim Ball. But first I want to take two minutes, because Commissioner Delaney is going to join us by phone and he said he would be available at 11:00. So if the department could get him on the phone. We will take just a two-minute break and get that set up.

(A brief recess was taken.)

MS.TURNER-BAILEY: We are going to reconvene. We are going to move on to our next agenda item. We are doing to continue to try to get Commissioner Delaney on the phone. We haven't been successful so far. We are going to move on to hospital beds, sub-areas and bed need methodology. And apparently there is a presentation. Could someone do something with the lights? Jim Ball, chairperson, Hospital Bed Ad Hoc Advisory Committee.

MR.BALL: Good morning and thank you. My name is James F. Ball. I'm the assistant director of health care plans for General Motors Corporation. I have represented the Michigan Manufactures Association on the hospital bed ad hoc and have served as chair of that committee. I'm appearing before you today, or we are appearing before you today to give what I hope will be the final report of this ad hoc. For that matter, since I think this is the last remaining ad hoc under the old format, it is probably the last report of any ad hoc. This is not a report for final action. We will be recommending that you tentatively adopt our recommendations for movement forward to public comment. Dale Steiger of Blue Cross and Blue Shield of Michigan and Bob Zorn of the Michigan Hospital Association will be making the primary report today, but before they do I would like to make a couple of comments. Particularly for the benefit of the newer Commission members.

This ad hoc was originally impaneled over three years ago. The Commission gave us a series of charges, and as we completed each one, or sometimes even before we completed work on an existing charge, a new issue and charge would come up. Over the life of the ad hoc we provided you with recommended standards on long-term acute care hospitals, or LTACs, or hospitals within hospitals, and relocation of non-rural hospitals and relocation of beds within sub-areas, on transferring of beds from closing hospitals to high occupancy hospitals, and allowing high occupancy hospitals to obtain limited numbers of additional beds when they are unable to meet the needs through other means. One of the early charges in June of 2000 was to recommend adjustments to the standards that would allow rerunning of the hospital bed need calculation. The then current bed need had been calculated years before and was out of date. Updating with new census data was warranted. We completed that charge, but in the process identified several areas where we felt underlying methodology warranted review. A couple of quick examples were whether neonate or pediatric or ICU beds should be treated in the same way as general surgical medical beds and whether there should be adjustments for age cohorts given the variation in use patterns associated with different age groups.

The Commission agreed and gave us a new or additional charge to recommend changes in the methodology. To simplify the process in light of the extremely technical nature of the subject, rather than reconstitute or expand the ad hoc, in March of 2001 the Commission authorized use of a Technical Advisory Committee. It has been operating since that time and, I must add, has demonstrated a great deal of diligence. While I did not personally participate in their sessions, I know that they deliberated long and hard on multiple points and did not arrive at recommendations to the ad hoc until issues had been fully explored and consensus had been reached. The meetings were open ones with only a few ad hoc members participating.

At the risk of leaving many important people out, and Dale can add to my comments later, I would like to recognize the efforts of Dale and Cheryl Miller of the ad hoc, Mark Mailloux of U of M Health Systems, Bob Meeker of Spectrum Health, Mary Beth Milliman of Munson, Peg Reihmer of Botsford and Bob Zorn of the MHA. I would also like to recognize the major contributions of Stan Nash and Larry Horvath of the department, without whose assistance this effort could not have been concluded. The bottom line of the report you will be hearing today is that we are recommending that some sub-areas be modify and others reduced or eliminated and that the need methodology be modified. If you accept our recommendations and move them forward for public comment, it will reduce the number of sub-areas by seven and increase the calculated bed need by about 2,500 beds. I should note that the earlier rerunning of the data resulted in about an 8,000 bed reduction in the calculated need, so these recommendations will restore some but not all of that number. Also the current bed inventory will continue to be well in excess of the calculated need, and there will be no sub-areas which will be in an underbedded status.

A couple of final points are that the ad hoc is not saying that this should be the end of the matter as far as the Commission is concerned. For example, there was a sense that additional adjustments should be made to recognize rehab and ICU beds because they cannot be readily converted from one use to another. But there is no common and consistent reporting of such beds today. We suggest that you urge the department to remedy this, and, once it is done, to revisit the matter.

Similarly, at the prior Commission meeting there was a suggestion that the ad hoc was remiss in not taking various socioeconomic considerations into account. There was debate about whether or not it was technically within our charge, and in an exchange of correspondence between Chairperson Turner-Bailey and myself it was confirmed to be within our purview. However, it' s probably a moot matter. Ultimately the TAC and ad hoc concluded that those were more subjective issues and the proper place for them is in the comparative review standards used to determine priority among competing proposals once it is objectively determined that there is truly a need for additional beds in a particular area. The TAC did not feel it had the necessary expertise to fully explore those issues and the ad hoc agreed.

We note that there are no comparative review standards in the hospital bed area and believe that you should address it. The TAC had a list of items that were suggested to it, but it is by no means an exclusive list. I believe you have also received a letter from Lody Zwarensteyn of the Alliance for Health in Grand Rapids suggesting additional items. Should you undertake your own deliberations on comparative review standards or impanel a body to do so, the TAC would be happy to provide you with a head start by sharing the information they gathered and/or content of their discussions. You may also want to involve members of the TAC in that discussion. With

those preliminary comments, I' m going to turn the floor over to Dale and Bob to explain the background of what we are proposing, and then the department can explain how it' s reflected in the proposed standards. Gentleman?

MR.STEIGER: Thanks, Jim. My name is Dale Steiger. I' m with Blue Cross. Bob Zorn here on my left is from MHA. And we are going to attempt to walk through this presentation fairly quickly. It was mailed out to all of the Commission members last week. I' m going to assume that everyone has at least gone through it lightly if nothing else. I would like to go to the first slide, to the membership of the Technical Advisory Committee. When we first started this process a couple years ago I would have thought that altruism was either dead or dying, but after working with this group of people for the last few years, I' m happy to say that this is a very professional group of folks, very technically competent, and just excellent folks. They really looked, as we went through this process, at what was best for the community. And although all of them represent various organizations, many hospitals, basically everybody checked their organizational strategy at the door and we worked in the last two years on really what was best for the community. I have been very impressed with that. We tried to be very objective as we went through things, and I think as we walk through this you will see that I think we have done that. We started as a very small group that was appointed by the Commission. As time went along we added people as they wanted to participate, so the group has grown to be quite large here. It represents an awful lot of organizations around this state. As I said, we opened this to anyone who wanted to participate. We have folks on the mailing list, for example, who wanted to be on the list who never made a meeting. But we tried to be as open as possible. I would like to say that this is the membership of the 2002-2003 Technical Advisory Committee. This group made revisions to the existing methodology. And we will get into some of those revisions as we go along. But I want to point out, if you turn to Appendix B, and we won' t shuffle our paper, but I passed out one page a few minutes ago -- it is double-sided -- for the work we have completed the last two years really was begun 25 or so years ago by both the Michigan Health Data Corporation and the Michigan Acute Care Bed Need Methodology Project. Both of those projects took place in the late seventies. The Michigan Health Data Corporation, if you look at Appendix B you will see all of the organizations that participated in that. It includes Michigan State Medical Society, the Osteopathic Association, basically all of the universities in the state and a lot of other organizations. So when these methodologies were put together 25 or so years ago there was a lot of brain power, a lot of fire power that went into these things.

I wanted to make sure that we all understand that what we are talking about today really is not something that the 2002-2003 Technical Advisory Committee came up with, but basically this group that has worked the last two years looked at what was done years ago, made decisions as to what was good, what needed to be changed, and we went from there. So I think it was important to point out early on that we had a lot of other organizations years ago that were very influential in doing this. I' m going to try to move through this fairly quickly so that we have as much time for comment and questions. I would point out that there' s two ways to approach this. Certainly everyone on this list, including myself, understands everything. There is a difference, as far as I' m concerned, between understanding things and being able to explain things. So as questions come up, I' m going to refer some of the answers to other folks. We have a lot of people here from the Technical Advisory Committee, and as questions come up, when it' s appropriate, I' m going to refer the answers to other folks. Basically I got selected as chairman because I was a pretty face. If you' ll look at page 5. We won' t spend a lot of time on the charge. The charge was given to us by the Commission back a couple years ago. We have interpreted that charge to be looking at the sub-area redefinition, taking a look at the methodology to see if it was appropriate. We also looked at the bed need methodology to see if that was appropriate, needed changes. And out of both of those methodologies we are going to recommend to you that we have new sub-areas, revised sub-areas and revised bed needs. Page 6 is basically the history of what' s gone on over the last 25 years. We have HSAs, obviously, in this state. They originated back in the early seventies as part of 93641, the Social Security amendments of 1972.

I' m not going to go through each of this line by line. I think it' s important that the Technical Advisory Committee this year and last year reviewed the HSA boundaries, determined that in most cases these boundaries were reasonable, given the patterns of care that exist in this state. We looked at those HSA boundaries and we basically concluded that there was no need to change them.

You will see as we go through that there were a couple of hospitals that were put in sub-areas that are outside HSA boundaries, but 99.9 percent of the time the HSA boundaries that are drawn we feel are very adequate for what we are trying to do at this point. Under sub-areas it is noted that the original clustering took place in 1978 as part of the acute care bed need methodology. Appendix B, which I believe was distributed to all the Commission

members, illustrates the methodology and the thinking behind the original sub-area clustering methodology. We looked at that methodology, concluded that it still made sense with a few revisions, and we have continued to use that.

The underlying premise for that methodology was basically the hospitals that serve a common market should be clustered together for planning purposes. For community planning purposes. And I think someone in our group came up with the phrase patterns of care, existing patterns of care, and that's what basically the sub-areas reflect today. There's a couple of small bullets beginning in the 1970's. We determined that -- we learned as we went along, Peg Reihmer, one of the esteemed members of our group, was part of state government at that time and played a very significant role in helping to decide or define those original sub-areas, was very helpful as we worked these through in terms of revising it.

And you will note the last bullet on that page, the conclusion is that the process that we needed to follow, the process that was followed under John's tutorage 20 years ago was basically a combination of discharge data, primarily discharge data and expert judgment. And there were a few cases in the sub-area realignments, for example, that we applied expert judgment. As I said, this is a group of very altruistic people who were making these judgments based on community need and the good of all the residents of the state. Under the bed need methodology history, we are talking basically the original bed need methodology here. Again completed in '78. I believe Appendix A refers to a fairly, about a half inch thick, half an inch set of pages that was part of the original methodology. I believe the indication was that if anyone cares to look at it, they can approach one of the department members and get that. There is a lot of stuff in there. As I said before, I think every member on the committee understands it. Stan Nash was the person who put it together and helped us work through it. I think the important point on this page is that the original approach used the normative approach for use rates. The normative approach as it was applied in the original bed need methodology had use rates to be either in each sub-area, the use rate was either the lower of the sub-area's specific rate or the statewide average. Basically the thinking was at that time -- the average use rate across the state was over 1,200 days per thousand people, per thousand patients. The thinking was that the use rate was way too high and the normative approach was adopted so that those areas of the state which had extremely high use rates wouldn't be rewarded in the bed need methodology for those high use rates. Page 8, bed need methodology revised. This basically deals with the 2001 run that was undertaken by the Bed Need Ad Hoc Committee and published by the department October of 2001, I believe it was. Going back to a note that I have, that run in 2001 produced the statewide bed need of about 17,300 beds. And that was down from the original 1999 bed need of over 25,000, due primarily to the significant drop in use rates from 1989 to when the methodology was run again in 2001. The last three bullets on that -- and I want to make sure that I can read it. The last three bullets on that page basically are decisions that were made back in 2001 by the ad hoc committee -- not by the Technical Advisory Committee, but the ad hoc committee -- as a way of expediting the 2001 and getting it on board. As we move into the approach that was taken by the Technical Advisory Committee, this first page deals with the process to redefine or revise sub-areas. As is noted there, we took a look at two basic methods; one was a Wennberg method and the other was John Griffith's methodology that we ended up using.
The Wennberg methodology was rejected by the Technical Advisory Committee after some study because it ended up being based on 1992-1993 Medicare data, was only Medicare data in the State of Michigan to define the Wennberg sub-areas. Subsequent to that Blue Cross data was folded into that Medicare data and the medical process, medical outcomes were looked at. But the original sub-areas, service areas in the Wennberg process were based originally on Medicare data.

This also came out to be 109 hospital service areas as part of that process. We felt that was way too many. It was very bulky, very difficult to work with. Also if you noticed in the Wennberg documents, Wennberg also indicated that they, they went through a computerized methodology based on patient demographics and patient usage and was also a visual review that the Wennberg folks made when they defined these sub-areas. So we have applied professional judgments; the language that's used in the Wennberg documents is visual review. The other issue that was kind of the final determinant in not using Wennberg is we were unable to get the programming from their organization to apply it to Michigan, to our process. We did look at John Griffith's methodology in detail. As we noted here, John was at a TAC meeting or two, went through his methodology. Again, emphasized that it includes two components, one is an analysis, computerized analysis of patient care data, and the other, the other way, the other issue is review of the analysis by an expert group such as our own Technical Advisory Committee.

We ended up using the Griffith methodology because we feel it's population based, it's Michigan based and reflects actual patterns of care based on the 2001 data that we ended up using. The next part of the approach is the bed need methodology. We knew from the beginning that there were very significant issues that needed to be dealt with under the methodology. These issues were brought to us by a variety of people on the committee. Bob Zorn, for example, had some concerns about the initial, the bed need methodology as it existed when we started. Those major issues were the normative approach, the planning horizon, how far we would look out in the future, other med/surg beds such as OBP's, ICU, CCU, those kinds of things, and target occupancy. And we will go through those very quickly in the next couple of pages.

The normative approach, as I indicated before, was the use of the actual sub-area use rate or the statewide average, whichever was lower. I think this came about back in the days when occupancy was very high, use rates were very high, and it was put into effect to counter basically the roam's (phonetic) law or roamer's law to basically build bed at a facility. If anybody was around in the late 70's or early 80's before (inaudible) came in, that was pretty much true. It indicated on that slide the use rate was over 1,200 days per thousand. The use rate now statewide across Michigan is less than 600 days per thousand. It is a pretty significant drop over the years.

But there is still a very wide variation in use rates, as we will see, very wide variation in use rates in different areas of the state. You can see here managed care and other payor pressures have squeezed out more excess utilization. I think that's reasonably true.

But the problem that we had as a group, and again it was brought to us through the auspices of MHA primarily and MHA folks, Bob Zorn in particular, convinced the rest of us the use of the normative approach did not really reflect actual inpatient bed need in lower income areas and lower socioeconomic areas. So we needed to come up with a solution that would deal with that particular issue. The thinking was that even though the use rates, the inpatient use rates were higher in some of these areas, that this was not a reflection of people inappropriately utilizing inpatient beds, but rather it was a reflection of the need in those areas because of other lack of primary care facilities, those kinds of things.

If you go to the next page, page 12, the axis on the left is basically the use rates. Remember again I said that the statewide average right now is around 600, slightly less than 600, so you have -- and then across the bottom are a collection of zip codes basically aggregated by income. So if you look at the left, the lower income areas, lower income zip codes have significantly higher use rates than in the middle and on the right.
And I noticed yesterday as I was going through this, if you go out to the right-hand side the use rates, the blue columns, the use rates start to go back up again. And I attributed that to the fact that as we get older maybe we make more money, we have higher incomes -- not in my case, obviously -- but as folks get older their incomes go up and the use rates go up also. Another issue, as I mentioned before, was the planning horizon. Particularly the providers in our group felt that a five-year horizon really is too small, that we really needed a ten-year horizon. Just because of the timing issues, the data that we used in this particular case is 2001, the projected population up to 2006 until the data comes out, the projections are made, the Certificate of Need applications are filed, folks just felt that if there was a need, by the time the facilities were constructed it would be too late. So the conclusion was that the optimal horizon would be ten years. We will talk later on that that's the optimal and not practice. Another issue was OB and Peds beds. These beds are not interchangeable on a daily basis with med/surg beds, so we felt that we really needed to deal with different kinds of beds in different ways. Obviously they have different use rates. They have different target occupancies. So the decision was made to segregate medical surgical beds from pediatric beds from OB beds. There are people on the committee that would like to see us have a further breakdown in some other kinds of beds, but at this point we felt that there really was no way to consistently differentiate these other kinds of patients and differentiate these other kinds of units. So at the current time we are dealing with the three types of beds, med/surg, OB and pediatrics. Target occupancy was a major issue. Obviously if you go through a pure bed need calculation, we all understand we can't run a hospital at 100 percent occupancy. The thinking back in the 80's, for example, was you could run hospitals consistently, the med/surg portion of the hospital consistently in the low nineties. I think that was the original target occupancy that was built into the methodology was 91 percent. There are a lot of things have changed over the past years. Many hospitals now are running very unique units. It is very difficult to move patients back and forth between these kinds of units. And there are also seasonality issues. Page 16. I'm not going to go into this at all. We did look at some other states' methodologies. We determined that Michigan had significantly better methodologies than anyone else, and in most cases other folks had very, very crude things that we did not want to be involved in. Page 17, the Griffith methodology. And again, Stan Nash was infinitely invaluable to this because basically all of

the programs for those methodologies have gone away as the Michigan terminal system went away, and I won't bore you with what that is. Page 18, the final application of the sub-area methodology. Again, this was agreed to by all. I don't think I pointed out enough back when we talked about the membership, every action that this group took over the last two years was by acclamation. There were no negative votes for the people that were participating in the process at whatever meeting it was. And again, it was a very open process. All the actions that we took were by acclamation. They were agreed to by everyone in the room. We had discussion, obviously, as things went along, and from time to time we changed things, but ultimately we agreed as a group. I'm not going to go through all of this detail at this point. If you jump forward -- well, actually, let's go to page 20, Bob. This is the outcome of the sub-area analysis. HSAs 4, 7 and 8. As we went through the analysis, essentially there were no -- there were so minor changes in these three HSAs that we basically did not make any changes at all. So the sub-areas in these three HSAs are exactly the same as they are in the current standards.

As it says, HSAs 2, 3, 5 and 6 had some minor changes. Again reflecting current use patterns. The major changes were in HSA 1. We obviously have population changes. We have fewer hospitals than we had before. What we attempted to do here was get as detailed as possible in terms of what happened with the sub-area assignments.

As noted before, there are three hospitals in the state, three very small hospitals where the populations, population in their area essentially goes across HSA boundaries to get care, and so we did make those changes. We did not stick -- you know, originally those were Gratiot, Mackinaw Straits -- and help me, Bob. The third one was?

MR.ZORN: Borgess-Pipp.

MR.STEIGER: Right. There were also three other hospitals that had kind of a unique situation because they bordered other states. We had discussions about having the other states' data in or out of the methodology. You can essentially see what decisions were made with those three hospitals, Hillsdale, Sturgis, Mercy Monroe. Again, these were decisions that were made by the committee based on what we felt to be the best strategies for the state. I think you all have sub-area maps in your packet. There are also individual listings of each, of the hospitals in each sub-area. I'm not going to go through that in an effort to save some time. The sub-area maps, I believe, are in Appendix H also -- not maps, but the sub-area listings are in Appendix H which I believe were distributed with your packet. Let's take a few minutes and go through the bed need methodology itself. I noticed yesterday as I was going through the material that we really don't have an equation in there in terms of what bed need is. And basically, when we calculate bed need in this state we use a projected population, what is the population in a given area, what is the use rate in a given area -- and again, we are using actual use rates, what are the use rates in terms of days per thousand. You end up multiplying those two together you get total days, divided by 365 you have average daily census, and you apply an occupancy target to it and that ends up being the bed need for that particular area. Under the population forecast on page 25, as I mentioned before it was impossible to get population forecasts at the zip code level for more than five years out. So we are restricted to making our projections based on a five-year horizon. The numbers that you have in your package, the numbers we are talking about today are basically bed need as projected to 2006, based on 2001 use rates, based on what Claritas, I believe it is, an organization that projects the population in each of these sub-areas in 2006. We did make what I think are some fairly significant changes in terms of the age cohorts. We used four age cohorts before. We basically broke the 15 to 64 age cohort down into two age cohorts: 15 to 44 and 45 to 64. There is a graph in here on page 29 which indicates why we did that. It is a good graphic portrayal of what use rates are for various age cohorts. And obviously if you are in an area which deals with an older population, you want to make sure that the use rates that are built into our methodology reflect what actually goes on in your area. As I mentioned, we, page 27, we ended up with only pediatric, obstetrical and adult med/surg. We essentially do all of the calculations individually, separately for these three types of beds, and then aggregate the bed need back into one final number for each one of the sub-areas.

Target occupancy. Again, target occupancies initially were set at 91 percent. We felt what was too high. When the numbers were rerun in 2001, the target, maximum target occupancy was dropped to 85 percent and an average daily census of 200 beds. After pretty thorough review, particularly by Bob Zorn and Bob Meeker, we ended up coming up with a nonlinear scale which essentially gets us to 85 percent occupancy as a target, but at an add daily census of a thousand beds. We have significantly liberalized what the target occupancy needs to be in each one of these sub-areas to account, again, as I said before, to account for seasonality and for the fact that

many hospitals are running fairly unique units where patients are not moved back and forth. Again, that, as I noted before, the total bed need went from 17,000 to 19,000. Quite a bit of that is a result of changing the target occupancies. Page 30. I think the two significant things are the bed need methodology be rerun every two years. That's already been approved. The sub-area configuration should be updated every ten years, and that's already been approved in prior meetings. The individual bed need numbers in sub-areas -- Larry, I'm not exactly sure how that was given to the Commission. But I assume it was given as a package the same as the -- so everyone has that?

MR.HORVATH: Yes.

MR.STEIGER: These are the numbers, the bed need numbers we are recommending. These are the bed need numbers and sub-areas we talked about before. The sub-areas, the bed need numbers, the changes in methodology, these were all approved by the Bed Need Ad Hoc Committee last week. Essentially I think these are the things we are recommending to you today to approve and send out for public comment. That was quick, fairly dirty. Are there questions? And I would basically throw it back to the others.

MS.TURNER-BAILEY: Are there any questions? Commissioners?

MR.HORVATH: Renee, could we recognize Commissioner Delaney on the phone?

MS.TURNER-BAILEY: Okay, thank you. We did successfully get Commissioner Delaney on the phone. Commissioner Delaney, can you hear us?

MR.DELANEY: Thank you very much.

MS.TURNER-BAILEY: Any questions? I do have several cards. Thank you very much. Okay, before I'm going to start taking public comment, here -- I do have several, quite a few cards here -- I just want to take a moment to acknowledge and thank the work of both the Hospital Bed Need Ad Hoc as well as the TAC. And I'm going to call out Chairperson Ball, but certainly there have been many, many people that put in many, many hours over the last several years with this committee and I just want to personally, and hopefully the Commission backs me up on this, thank you for the work that you have done. So thank you very much.
We are going to start by taking cards. James Ball, I have a card for you. Did you want to make a separate comment.

MR.BALL: No.

MS.TURNER-BAILEY: Brent Larson?

MR.LARSON: Good morning. My name is Brent Larson. I am a legislative advocate for Borgess Health Alliance in Kalamazoo. I will make my comments fairly brief since it seems to be close to that time. Thank you very much for the opportunity to express our views to the Commission concerning the proposed new sub-areas for determining bed need of hospitals throughout the state. We also are very grateful for the work that has been completed in bringing forth this recommendation, and we are grateful for the expertise and the thoughtful nature that this has come about. However, we have some concerns about the proposed sub-areas and how it appears that the stated criteria for developing them have been applied in at least a few cases inconsistently. We suggest that further consideration be given before the proposed new sub-areas receive final approval by the Commission.

In reviewing the materials in the proposed sub-areas as they have been developed thus far, we believe that there has been an overly subjective nature in a few cases in applying the bed need model to determine proposed new sub-areas as well as a sometimes inconsistent application of the stated criteria for determining the placement of some hospitals in these new sub-areas.

For example, in our southwestern region of Michigan, we believe that the proposed sub-areas include an inappropriate placement of Sturgis Hospital into the proposed sub-area referred to as 3A that also includes the Kalamazoo hospitals. In the presentation by the Technical Advisory Committee it was stated that it was determined using the data model that Sturgis Hospital most appropriately belonged to a cluster with Indiana hospitals It was further stated that because of this fact, and because there is a desire to reduce the number of

single-hospital sub-areas, Sturgis was placed with the Kalamazoo-oriented sub-area even though this determination was not made by applying the data model in an objective manner. We expressed our concern about this case to the Bed Need Ad Hoc Committee at its December 2nd meeting, and several speakers at that meeting stated that our concern about the Sturgis placement seemed to deserve further consideration.

In a second case we have discovered since that December 2nd meeting, we have identified another hospital sub-area placement in our region that seems to also warrant further review. A new sub-area is created in the proposed list of sub-areas that combines Borgess Lee Memorial Hospital in Dowagiac and Lakeland Hospital in Niles. In the new proposal, this is referred to as sub-area 3D. Grouping these two hospitals significantly alters the bed need calculation for this area, and particularly for the residents in Cass County. In fact, the change results in a bed surplus in an area that currently is estimated to have a bed need.

In both of these cases the question of Sturgis and also the question of grouping the Niles and Dowagiac facilities together we sought the assistance of the Michigan Health and Hospital Association to gain further insight as to whether market share and other data might suggest that further review of these two hospital sub-areas placements would be appropriate. The information we received from them indicates to us that the proximity of these facilities to Indiana led to a more subjective review of the data and a decision to make these groupings that seems to be outside of the intended manner in which the model to determine sub-areas was to be applied as described in the presentation from the Technical Advisory Committee. The desire for fewer single-hospital sub-areas was expressed in the Technical Advisory Committee' spresentation at the CON Bed Need Ad Hoc Committee meeting on November 5 and was affirmed again at their December 2 meeting. The rationale for achieving this outcome was the changing nature of health care delivery into larger referral systems rather than single provider areas. It would follow, therefore, that a smaller hospital would be placed in sub-areas with larger facilities based on levels of shared market share, referral relationships and other data. We believe that this rationale makes sense. We do not believe, however, that this rationale has been consistently or appropriately applied in some cases.Since the review of data showed that Sturgis Hospital is more related to Indiana hospitals and referral relationship, we believe that it does not make sense to place them in the Kalamazoo sub-area as an arbitrary alternative, rather than assigning them to their own sub-area as is the case for Hillsdale Community Health Center, and for Community Health Center of Branch County in Coldwater in our part of the state, and for other facilities across the state under the proposed new sub-area configuration.

We are also concerned about the impact of the proximity of Indiana referrals in the case of grouping Lakeland Hospital in Niles with Borgess Lee Memorial Hospital in Dowagiac. Due to these concerns and others you may hear throughout the course of this meeting, we request that the Commission either recommend the affirmation of the current sub-area configurations until a more effective model can be developed and applied in a more objective fashion, or at the very least, we request the review and potential for correction of what we believe is an inappropriate placement of hospitals into the newly proposed sub-areas. And we appreciate the opportunity to present our observations and our opinions.

MS.TURNER-BAILEY: Are there any questions? Commissioner Hagenow?

MS.HAGENOW: What' s the impact of these two areas having the small hospitals put into 3D and 3A? What' s the outcome of that decision?

MR.LARSON: The outcome of that decision in looking particularly at Niles and Dowagiac, currently, based on the feedback that we received, there is a bed need somewhere in the area of 28 beds. If this sub-area configuration bringing these two hospitals together comes about, the need goes to a surplus of four beds. That means a significant impact if future beds are sought in that area, and particularly in Cass County. And again, we know this is not based on county geographic boundaries, but it changes the picture pretty significantly for that particular area.

In the area of Sturgis it changes potentially the bed need movements over time. And those specific movements may be unclear now, but we are concerned that this be looked at in a very deliberative way, particularly if this is a configuration that is to stay in place over the next ten years.

And so our concern is that this process be handled in an objective manner, as objectively as possible. And that the amount of subjective decision-making be minimized to the extent possible. And at least in these two cases,

and we haven't reviewed the entire list of sub-areas, but in our own sort of neck of the woods these were two things that popped out at us that raised the question: Is this really the best mousetrap to use at this time.

MS.TURNER-BAILEY: Any other questions? Mr.Ball?

MR.BALL: If I may, Madam Chairperson, if I can respond to some of the comments I would like to do that.

MS.TURNER-BAILEY: Okay.

MR.BALL: On the Sturgis matter, subsequent to our last meeting one of the ad hoc members was at another meeting at which the CEO of the Sturgis Hospital was present, and the CEO indicated that what had been done did make sense. That 95, 90 to 95 percent of their referrals do go to Kalamazoo with the balance going to Fort Wayne, Indiana. Now I, you know, I had that input. I don't know if anybody from Sturgis is here today. I don't see any indication of that. My intent was to pass that on and ask them to appear either by letter or to actually appear at a public comment session or at a subsequent meeting of the Commission to address that.

MS.TURNER-BAILEY: Okay, thank you. Are there any questions? Robert Asmussen?

MR.ASMUSSEN: Good afternoon. I'm Bob Asmussen, St. John Health, and am or was a member of the bed ad hoc committee. I appear this afternoon to indicate that I voted against the recommendation to bring the bed ad hoc or the bed ad hoc issues related to sub-areas to this body. And I would like to tell you why.

The concern, or at least another way to put it is the opportunity for the TAC and bed ad hoc to improve the planning significance of sub-areas was missed. And I would point out to you that the current tweaking of sub-areas, which people could argue for or against the tweaking, that's not the issue from our perspective. The issue is that the formula does not respond to population shifts.

And if you think back to 1978 or whatever year it was when a snapshot was taken and the formula was used, the population and institutions in this state were probably fairly appropriately located. Almost 30 years have gone by. People have moved. And by virtue of other standards in the Certificate of Need process, the ability to relocate hospitals beyond two miles has been prohibited. So there is no opportunity to respond to significant population shifts without boundaries. And this formula is a clustering process given existing institutions, and obviously if you have a population that has no hospital, they will migrate to current institutions. And this formula adequately captures where folks go, but does not answer the question is that population base now sizeable enough to justify its own institution.

And I would use Oakland County as an example. It's the one that we are obviously most familiar with. If you divide, artificially divide Oakland County into half, east and west, there are 2,929 hospital beds on the east side of the county. There are 150 on the west side of the county. In 2002 the population of the east side of the county was 717,000 people. The population on the west side was 491,000 people. According to SEMCOG information, the growth pattern for both sides of the county, on the east side by '07 it will grow 1.78 percent, on the western side of the county, 5.48.

So for sub-area 1A, which under the new recommendation encompasses all the hospitals in Oakland County except for Botsford, and that's somewhat curious and you might ask someone else about that, there is identified under the new bed methodology, 715 too many beds. And according to the recommendation, and perhaps it's in the language, the re-examination of sub-areas, if you adopt what is presented, will not be done again in ten years -- for ten years. So literally there will be no opportunity, particularly if the Plaintiffs in the case against Public Act 619 prevail, for any areas in the western side of the county to be able to end up with a hospital. And obviously the population and the need is there. When the legislature examined this question in talking about developing or passing Public Act 619, they looked at the sub-area question and concluded, likewise, that it was no longer responsive to modern day population and that the HSAs were a more appropriate planning process or provided reasonable geographical limits for planning for hospital beds. And this particularly given the fact that 65 percent or more of the state's bed are either owned or controlled by systems. And so by virtue of these artificial clustering, based on 1978 population, makes little or no sense.

And so from our perspective, we would urge the Commission not to adopt the sub-area recommendations, but rather to request that additional work be done on this question and come back with a more realistic 2003 proposal. While I am here, all the rest of the recommendations of the ad hoc and the TAC I think are appropriate. The bed need changes, all of those pieces deserve your support. Thank you, and I will be happy to respond to any questions.

MS.TURNER-BAILEY: Are there any questions? Commissioner Hagenow?

MS.HAGENOW: I need to repeat back to you to see if I understood what you said. You are saying that rather than use the old sub-areas that have been there, that there should be a higher look at where populations are, and the designation of sub-areas shouldn' t, the tail shouldn' t wag the dog, we should look at the population and then set the sub-areas and not take history and say here is the sub-areas and just move them forward.

MR.ASMUSSEN: Correct. Correct. And if you adopted a methodology that encompassed boundaries, then you do capture population. But this methodology or this formula simply clusters existing institutions. And so it is oblivious to the fact that half the population of, say, Oakland County is moved someplace else.

MS.TURNER-BAILEY: Commissioner Sandler?

DR.SANDLER: I really have not a question to Bob but perhaps to Jim Ball and Dale Steiger to follow-up on the point made. How many -- you may want to stay to comment.

MR.ASMUSSEN: Okay.

DR.SANDLER: Did you decide how many sub-areas were going to be within one HSA? And was this population based, was the minimum population, was it distance traveled? Please help us for the criteria of HSA grouping, the sub-area grouping for the HSA. I think that' s the poithyou are trying to make, if I am not mistaken.

MR.ASMUSSEN: Not really.

DR.SANDLER: I' m mistaken.

MR.ASMUSSEN: In fact, the TAC and the bed ad hoc endorsed the fact that there are seven less sub-areas. But again, unless you get away from using a formula that simply identifies the clustering of institutions and where people currently seek care, you are not going to respond whether you have ten more or ten less sub-areas. This formula does not recognize the fact that hospitals do not exist. So, in effect, you could have under this formula three million people living in western Oakland County and this clustering methodology would not suggest a bed need unless the entire county population got large enough to cancel the 715 bed overbedded situation, which then allows, if in fact there is a bed need in a sub-area, then would allow the movement of beds under comparative review.

DR.SANDLER: Perhaps they need to respond to do they take into account population.

MR.BALL: I think the argument is no matter how you reconfigure the sub-areas, there is no need for beds. What you are talking about really is a distance issue or convenience issue. But if you took Oakland County as one large sub-area or one HSA or whatever you want to call it, the bottom line is that there is still no need for beds in terms of current utilization, current practice patterns in that area. And no matter what you do with the sub-areas, you will still see no need for beds.

MR.BREON: Can I ask a question?

MS.TURNER-BAILEY: Commissioner Breon.

DR.SANDLER: How do you, then, ever build a new hospital? It sounds to me like the formula proliferates the status quo and there is never a possibility of ever building anything new. How do you address that issue? Maybe I just don' t see how that gets done.

MR.BALL: I'm going to defer later to Dale to comment on the deliberations of the committee, but over time as hospitals either go off line, as existing capacity goes off line there may be a need. Or if there is some demonstrated change in the demographics in the use patterns and the disease patterns, and so forth, in the community there may be additional need.

I think ultimately it comes down to a difference of what does one mean by need. In the holiday period a lot of children say I need this item for Christmas. And it may be that they want the item or they desire the item, it would be nice if they could have it, but they don't truly need it. If you look at the references made to Oakland County, if you look at those hospitals in Oakland County, their occupancy rates are, you know, very low. There is no demonstrated need for them. Now, I suppose that if you slice and dice areas of the country and choose certain parameters or certain ways of presenting the material in a subjective manner, you could arrive at the conclusion that there was some need in an area. There is probably, you know, there's many two-block areas of the county that don't have a hospital in them. But is that the need? Now, I think Dale-

MR.STEIGER: That's as good an answer as I could give, really.

MS.TURNER-BAILEY: Commissioner Hagenow.

MS.HAGENOW: What about the two-mile rule, then? Because if indeed you have one part of the county where there is a large amount of placement, catchment, or hospitals that are based and you have a population moving to another part and you are going to spend money anyway, why wouldn't you allow them to be more responsive to the newer location, being that it might be five miles, ten miles rather than two miles? I wonder if that answers the question, because it still holds to the total bed capacity that you are talking about.

MR.BALL: If, you know, if the Commission wants to -- you know, over the life of this ad hoc we dealt with the issue of hospital bed relocation, and I don't today recall all of the detail involved in that. But if the Commission wants to revisit that, you know, that's your prerogative, obviously. You know, the mission that we had here was to say, you know, what should the sub-areas be for determining need and what should the adjustments be made to the calculation for need, and we did that. We weren't asked to address yet another review of the standard for relocation of beds.

MS.HAGENOW: But it is in your document, the two-mile rule. It doesn't source from someplace else, it sources from here.

MR.BALL: But that was in the past. It was not as a result of the current actions of the ad hoc.

MS.HAGENOW: I just think if we are responsive to population, then taking a look at that -- I mean, maybe that's an additional job, but taking a look at that would be critical to be responsive. And I don't know if that addresses the issue that you, Mr. Asmussen, have put forward. But it seems like it is not so much the configuration of the groupings but the allowance for matching the population with where the locations are with the facilities.

MR.ASMUSSEN: Well, you have hit on a point that Lody Zwarensteyn, Zwarenstein? -- long name -- we joked about at the last bed ad hoc. His suggestion when I made my point was perhaps this is the answer to the population shifts; namely, the replacement zones. But we have to remember what is currently standard, which is total replacement hospital, not the shifting of X number percent of your bed inventory to a new location. And secondly, in the one instance where we did deal with the movement beyond two miles; namely, Metropolitan Hospital in Grand Rapids, that allowance was some ten miles. But again it was only a pilot project and it expired. So the current standard still says two miles, and it's a total hospital replacement, not a shifting of a percentage of your inventory of beds to the community. But I would add that that is, as you suggested, a potential solution to the existing gridlock with the ability to move beds where people live.

MS.TURNER-BAILEY: Any further questions? Yes, Commissioner Breon.

MR.BREON: First of all, I admire the work that is done. I know these things are not easy. And you could work on it probably the rest of your life and not come up with something that everyone would be happy with. (LAUGHTER) I'm not suggesting that. But I am concerned, I just found out this morning we have no beds in Grand Rapids that are available for people and we haven't even started the flu season. I'm concerned about our

ability to respond to increase in utilization dependent upon certain times of the year and diseases. And I don' t see anything in here -- I know, according to the formula in here, we are still overblown by 500 beds in Grand Rapids. And I don' t know that there is any way you can do this, but clearly there is something that falls short when you have some organizations that are at capacity -- and I frankly believe they all are today -- but how do we respond to those kinds of things? And all the predictions that I have been reading is there is going to be an increase in utilization, not decrease in utilization, because of the elderly and everything else. And I know we are talking about a formula here and what the assignment was, but I am concerned that that somehow needs to be addressed on some time line that' s maybe a little quicker than ten years. Because I am concerned about how we are going to be able to respond. It is the capacity issues that I' m most concerned about, nothe overbedding issues. So I know it wasn' t the charge of this group, but it is a concern I think needs to be expressed.

MR.ASMUSSEN: I just comment with regard to your point. The bed ad hoc and the Commission did adopt a high occupancy provision which did allow Beaumont Hospital to add 94 beds. However, it too was declared a pilot project and expired, I think, at the end of 2003. So in order for that issue to come back on the table, the Commission would need to authorize work on that subject beyond the pilot.

MS.TURNER-BAILEY: Any further questions? Thank you. Greg Hudson. In case you are wondering, my plan is to continue to take public testimony until 1:00. And we sort of have limits on when our rooms are available and things like that. I know everybody is hungry, but I just ask that you indulge us just for a little while longer. Thank you.

MR.HUDSON: Good afternoon, Madam Chairperson and Commission members. My name is Greg Hudson. I' m the associate planner at Munson Medical Center in Traverse City, and I would like to read a letter into public comment from John Rockwood, our president and CEO. Hopefully my comment won' t be as controversial. Thank you for the opportunity to provide comment to the Commission regarding revision of the Hospital Bed Need Standards currently under consideration. I' m writing to you today to urge the CON Commission' s adoption of the recommendations of the Bed Need Ad Hoc Committee.

We believe the modifications to the bed need methodology encompass significant improvements over the current standards and provide a sound basis to assure an adequate supply of hospital beds throughout the state of Michigan. Specific improvements include the utilization of actual sub-area use rates, individual bed need calculations for special populations such as pediatrics and obstetrics, and realistic target occupancy rates which minimize the likelihood of patient turn-aways. These are appropriate and needed changes to provide a reasonable projection of bed need and allocation throughout the state.

In addition, Munson Healthcare, as a provider in many rural counties throughout northern Michigan, supports the exclusion of critical access hospitals from the MDCH bed inventory for the purposes of determining surplus. This federal designation recognizes the fact that these facilities provide much needed access points to the hospital services for rural communities and have limited services. Although critical to assuring access, these hospital beds, which generally run at a low occupancy, are clearly not interchangeable with those found in other acute care hospitals.

Munson Healthcare also supports the process used to redefine hospital sub-area designations. This effort was broad based, including participation by providers and planning professionals around the state. The support from both the MHA data services division and MDCH was both helpful and critical to the analytical integrity of the work product. As part of their work, the Technical Advisory Committee reviewed potential bed planning methodologies, including a survey of systems in use in other states. It was their conclusion that utilizing the methodology developed at the University of Michigan by Professor John Griffith with current statewide discharge data would provide the most accurate depiction of how inpatient care is delivered. The strength of this methodology is that it recognizes patient referral patterns and related geographic areas for specialized medical services offered at many facilities. A strict geographic basis for the calculation of bed need would not reflect the current patterns -- reflect current care patterns of hub-and-spoke systems which exist in both regions of the state and can seriously compromise access to hospital care. I appreciate the opportunity to share our thoughts with you on this important matter. We hope the Commission recognizes the value of the work of the Bed Need Ad Hoc and Technical Advisory Committees in developing recommendations which will strengthen and improve health care planning and access for the State of Michigan.

MS.TURNER-BAILEY: Are there any other questions? Thank you. Jim Budzinski.

MR.BUDZINSKI: Good afternoon. Jim Budzinski of Sparrow Hospital here in Lansing, Michigan.
I appreciate this opportunity to be with you here this afternoon. And appreciate -- first of all I want to say we appreciate all the hard effort, hard work and time and resources that the Technical Advisory Committee has put into the proposals that you are being asked to consider today.

We have participated in that process and we have observed the hard work and effort and thought process that has gone into it. And quite frankly, if I could characterize the proposals before you today in three broad categories, two of them we support and would thus strongly urge you to consider as health care' s changed a lot in the last 30 years since these methodologies have been put in place; in particular, it' s the updating of the acute care bed need methodology that we would support as appropriate, as well as target occupancies and things that we discussed for OB, pediatrics, et cetera. We think those are good ideas and would strongly urge you to consider those.

With respect to the changing of the sub-areas, we have participated in the bed ad hoc committee meetings to date through public testimony. Have essentially suggested that the starting point for looking at planning of health care is not at the sub-area level but is a broader framework at the HSA level. We probably have an honest disagreement as to whether or not those HSAs as currently configured are adequate considering today' s regionalized health care compared to, say, 30 years ago when they were first established. We have commented that our belief is that HSAs should be looked at again and updated with respect to today' s delivery of health care. There have been statements made by the Technical Advisory Committee that they believe that the health service areas are reasonably configured today even though they have not changed in 30 years. We take exception to that.

We have participated in various planning activities of the state in recent times. Unfortunately, because of the 9/11 situation there has been a need to establish regional planning areas for emergency preparedness. Sparrow has participated in that in the mid-Michigan region and, in fact, there are now eight emergency preparedness regions in the state reflecting today' s delivery of health care. Interesting to note they are somewhat similar to HSAs but appear to have been updated to reflect today' s configuration of regional health care as opposed to the original 1970' s version of HSAs.
So we would recommend that further consideration be given to updating health service areas as a first step in establishing a good planning process with respect to delivery of care, and we would ask you to defer accepting at this point in time the sub-area change proposed by the bed ad hoc committee. As an exhibit to the letter I passed out, you can see the emergency preparedness regions as currently defined by the state and a crude but a fair representation of the current HSAs. And they are similar in nature but they are different. And, of course, the emergency preparedness regions, for example, are much more current and have been looked at much more recently. And that' s what we would suggest. I understand also that there is a state group not only of the state but as well as hospitals who are regional trauma centers are looking to develop a plan and criteria for a state trauma system. I would tell you that my information to date suggests that the emergency preparedness regions appears to be the best framework that a regional trauma system or state trauma system could be categorized around.

So there is planning going on currently for a broader review of health planning areas, and we think that HSAs should be updated before sub-areas are modified or even tweaked at this point in time.
I would be glad to take any questions regarding this matter.

MS.TURNER-BAILEY: Commissioner Sandler?

DR.SANDLER: Yes. What methodism would you use to accomplish this (inaudible)? What is the process that you are recommending be followed since you have an idea that this needs more work.

MR.BUDZINSKI: With respect to looking at HSAs before sub-areas, I think the committee that has currently been charged with this could look at that. I think you might consider looking at outside, independent, objective resources. It is possible that somebody independent could take a look at these health-planning areas that are currently being looked at by the state and conclude whether or not there should be an independent review of the HSA configuration. Either way. But our point -- somebody said earlier, do we have the tail wagging the dog. To change the sub-areas without relooking at the HSAs seems to be a little bit like that to us.

DR.SANDLER: Thank you.

MS.TURNER-BAILEY: Any other questions? Thank you. Vin Sahney.

MR.SAHNEY: My name is Vin Sahney and I'm senior vice-president for Henry Ford Health System. I appreciate the opportunity to address the Commission regarding this recommendation of the ad hoc committee for hospital beds.

Let me right off the bat say that there are three areas in which I want you to really think about and look on the recommendation, about the recommendations. As a senior manager I have always been taught that before you look at the complicated technical formula, you should always have the assumptions that underlie that formula. There are three assumptions here, and two of them have been mentioned already. One assumption is do we start with the HSAs that were allocated 28 years ago? So that's a key decision point, because if you start with that and you say those are the HSAs, then obviously the committee did well.

The second is how do you take into account when population shifts? And I will read back the underlying assumption of John Griffith, and he states it clearly. Hospitals that serve a common market should be clustered together. That's his key assumption. So that means if in a distance of 50 miles in a sub-area population moves to one side of the county, by nature they have to go to the hospital that already exists, then they have to be clustered. And I think Bob Asmussen explained that very well.

The third assumption which has not been questioned is how many sub-areas to have within an HSA. And what should that be based under. Should there be just one sub-area? Should there be two, three, four, five, ten? And you will see that in the recommendation of this Technical Advisory Committee there is no method to the madness here. There are some sub-areas with a population of only 50,000 and there are other sub-areas with a population of 1.2 million. Well, what is that based on? Distance? Time to get to an emergency facility? None of those questions have been addressed in this formula. So I think as Commission members you need to ask the Technical Advisory Committee why not just have one sub-area? Sure it would show that HSA-1 has a lot of beds, but leave it as one sub-area. Why did they decide to make eight or nine? So I think we need to think about that.

So with that just let me point out some other problems with this. For example, in 1980, just two years after the methodology is proposed for HSA-1, which includes seven counties of southeast Michigan, 172,000 fewer people than it does today, why should there be fewer hospital sub-areas today when there are more people now in the HSA than back in 1978? And there is no explanation. In fact, in HSA-1 the recommendation is to reduce it to ten instead of 11. Oakland County hospitals, with the exception of Botsford, are grouped into one sub-area. And Botsford has been grouped with St. Mary's just below the border. The two little hospitals have been put together and all the other giant hospitals have been put into one. Why? It doesn't make any sense. We would suggest that Oakland County with over 1.2 million people should account for at least two sub-areas, maybe three, at 400,000 since the rest of the state don't even have that much population and they are account for numerous sub-areas.

Macomb County with a population of nearly 800,000 people, so almost 50 percent less than Oakland County -- (inaudible) previously were grouped into predominantly one sub-area now has been split into two. And so again the question is why there and why not at Oakland County. No rhyme or reason. Sub-area that Henry Ford Hospital is currently assigned includes 12 hospitals. Under the proposed assignment there will be 18 hospitals in the sub-area. Why? You know, why not just divide it into two sub-areas? I mean, again, since there is no restriction, there is no population, what was the methodology here?

A small sub-area with only two hospitals, Botsford and St. Mary's, has been created in western Wayne County. Why? I'm sure it was no personal reason, but when I look at the membership of the committee I have to ask, well, maybe there was a little bit more to this madness than what first appears. One conclusion that could be drawn from these observation is that there is some inconsistency in the sizing and grouping of these hospital sub-areas. I think the first step should be, are we going to first ask how many sub-areas, should there be some minimum population in sub-area and maximum distant? In a number of other states this methodology is used. One uses the maximum distance so people can reach an emergency room within a certain time or maximum population. So what other approach exists? Ad hoc committee did look at other approaches. In the appendix you see they

talked about New York, Ohio and other states, but they discarded it for considering John Griffith's methodology, which, by the way, is not used by any other state. Rejected by every other state.
Now, just so that you know, John and I are close friends. I have written a book with him, so it is nothing against John, it is just that it is an outdated methodology. We believe that the much simpler and more realistic methodology is to use population-based techniques. For example, an approach that allows for sub-areas to be created in urban counties that would serve increments of 400 to 500,000 people is a reasonable approach. There is nothing wrong with that. There is no more, you know, incorrect process here or anything. It is reasonable distance, reasonable population. That's the subarea. In rural counties, county boundaries could be used or a distance or time to access care could be examined. This approach that has been described does not recognize population shifts until well beyond the time the access become problematic. And I think the Commission agrees on this. You know, there are seasonable issues of hospitals running hundred percent. Usually month of January. And what happens is it takes four years to add a hospital. So it will be too late by the time you recognize that more beds are needed.

While the Technical Advisory Committee has attempted to keep the process as objective as possible, it is clear that a methodology that is predicated on maintaining the status quo will not fully serve future populations of healthcare consumers in Michigan.

So I think what happened is we latched on to the methodology without first understanding what are guiding principles. What guiding principles should be there that should really drive this whole methodology. If we decided that, then I think we would have looked at it that this does not produce the right answer.

I have done lot of mathematical modeling, and one of the key questions in mathematical model you ask is there face validity. Does it meet the common sense test? And I have to say that after applying this particular methodology that has been applied does not meet the common sense test. And the three questions that I raised are the ones that I think as commissioners you need to ask. I also in the question and answer before by Bob Asmussen, I looked at Appendix C that that was handed out. It says relocation of beds. And New York, for example, permits movement of beds within merge corporations. If there is a corporation and you want to move beds from one place to another, you can do that in the state of New York. So they looked at a different way of handling the question that was raised earlier. I will be glad to answer any questions.

MS.TURNER-BAILEY: Are there any questions? Thank you. Cheryl Miller? Oh, Mr. Steiger, I'm sorry. Cheryl, give me one moment. I think someone from the committee wants to make a comment.

MR.STEIGER: I wasn't going to comment- or I'm not going to comment on the individual items that were raised by Mr. Sahney, but I do take umbrage at his statement that some of the recommendations that came out of the committee may have been based on the individuals that were on the committee. I would point out that a number of speakers today that spoke have had representatives on the committee for the entire time that the committee was in existence. None of these individuals have raised concerns until the last week or so.
I commented to my wife last night, since we are in the process of re-doing our kitchen, that I would grab a piece of woodwork and bring it with me today to see what climbed out of the woodwork. But I really take umbrage at the fact that the accusation might be made that someone on the committee structured sub-areas based on their own individual organizational considerations. I think that is very unfair and very false.

MS.TURNER-BAILEY: Thank you. Cheryl Miller.

MS.MILLER: I hate these things. I swear I hate them. (lectern). My name is Cheryl Miller. I'm in the corporate strategic planning office at Trinity Hospital in Novi.

Mr.Steiger actually stole a little bit of my thunder, so I'll get us to lunch a little quicker. I would like just to reiterate this was a very objective group and a group that I am proud -- was proud to be a member of both the ad hoc and the Technical Advisory Committee. Each and every one of us checked our hospital IDs at the door. And to suggest otherwise is just not true.

Again, I was very proud to be a member of that group. We worked hard. Is it perfect? Of course not. Am I disappointed that if people had other ideas or suggestions or thought they had a better mousetrap that they did not share with us or participate or come to our open meetings? Yes, I agree with Mr. Steiger, it's very

disappointing. I would like to urge the CON Commission, as we often do, or as you often do, is to take proposed action to send this to public comment. Certainly a public hearing could be held by the middle of January, which would give ample opportunity to identify things like the Sturgis issue or the Lee Hospital issue, issues that may need to be readdressed. Give everyone an opportunity to look at the material, identify other possible areas, have the TAC or the ad hoc or some other group that will continue to work with the department to see if we can make changes and bring it back to you for possible final action in March. But I think it most advantageous to get this moving is to have a formal public hearing so that everyone can be heard and have an opportunity to go through the material more thoroughly. Thank you.

MS.TURNER-BAILEY: Any questions? Peg Reihmer.

MS.REIHMER: Good afternoon. My name is Peg Reihmer, and I am vice-president for planning, marketing and development at Botsford Hospital in Farmington Hills.

I sat as a member of the Technical Advisory Committee, and I am here really only to urge you to adopt our recommendations, or those of the ad hoc, actually, taken from our report, in their entirety for purposes of conducting a public hearing. The other thing that I would like to address, because I am -- I am flattered for somebody to think that somehow I could steer the results of our deliberations in a particular way. I did not, in fact. And I' m curious that Mr. Asmussen doesn' t recall the answer to his question that he asked at the ad hoc and that I responded to at that point in time. He has observed, as Dr. Sahney has, that Botsford is the only Oakland County hospital not clustered with the other Oakland County hospitals. That is really a function of the mathematical model that we used, unaltered, and reflects the pattern of use of Botsford Hospital. We get about 30 percent of our patients from the city of Detroit and another 35 to 40 percent from western Wayne County, which is why we clustered where we did. The hospital is located in Oakland County, but barely. 100 yards or so from the Wayne County border. That really is all I have to say at this point. Thank you.

MS.TURNER-BAILEY: Are there any questions? Okay, thank you. Patrick O' Donovan?

MR.O' DONOVAN: Good afternoon. My name is Patrick O' Donovan, director of planning for Beaumont Hospitals.

I participated in both the ad hoc committee and the Technical Advisory Committee that developed the proposed hospital bed standards that are before you today. And Beaumont supports these standard and we urge you to adopt them. We hope that any future proposals to authorize new beds or new hospitals remain under the scrutiny of the CON process and are evaluated using rational planning criteria, which was done in this case.

One of the criticisms of the bed need methodology is that it doesn' t account for population shifts within geographic areas that are served by groups of hospitals. While this may be partially true, this doesn' t mean that new hospitals should be authorized without determining if hospital access problems do, in fact, exist beyond anecdotal evidence. A drive time analysis would be one approach for looking at hospital access in various areas of the state where population shifts may be occurring, such as in Oakland County, Macomb County, Livingston County or any other areas of the state. It is important to recognize that the bed need methodology in the standards do take into account overall population growth within geographic areas served by the sub-areas. So, therefore, we urge you to adopt these standards for the purposes of public comment and put it out for public comment. Thank you.

MS.TURNER-BAILEY: Are there any questions? Thank you. Larry Horwitz?

MR.HORWITZ: Larry Horwitz of the Economic Alliance.

I would like to start off by shocking everyone and saying that I agree with Bob Asmussen. (LAUGHTER) These standards do not, and I reviewed with Bob what I was going to say, and he agreed that what I was going to say was in agreement with what he said and my suggestion of the response to it would make sense. So I want to share with you this miracle even prior to Christmas. (LAUGHTER) What this attempted to do was deal with bed need. There has not been a single person to come before you that has in any way commented or criticized the bed need formula. I said that was pretty good. Recognizing Peds and OBs, recognizing different ages, recognizing target occupancies better, lowering the target occupancies down to 60 percent so you only reach the 85 percent when you are in a very high, an area where lots of hospitals are. Or a lot of hospital beds are. There' s a whole series of changes.

So I would certainly urge you to send this forward if for no other reason than to have that useful work go forward. And because it is a matter of severe criticism of CON -- and the legislature doesn't distinguish between commission, department, law, standards -- that we have got bed need that was developed some time ago. Now we did perfect it, we dropped from 25,000 something to 19,000 something two years ago. But people said you didn't take care of this, and this, and this. So this is the fine-tuning of the bed need that bumps it up to 19,000. All right. All of the criticism here is related to the sub-areas. And here is the part that I would agree with Bob on. What is not dealt with here is the question that Commissioner Hagenow asked. Or maybe Commissioner Breon. What about the possibility that it would make sense to have a whole new hospital someplace in Michigan? All right? So it does not deal with the question of under what terms and circumstances should there be a whole new hospital. All right? And under what terms and circumstances should you be able to locate a hospital. Those two things I think need to be addressed. And that's where Bob and I, I asked him, I said, to me what you should do is go forward with this. And now go set up another process, which I believe under the statute requires it to be called a standing advisory committee made up a different way but is specifically charged with the relocation zone section. Right now it is two miles. This is your prerogative to change that number to any other number you feel like.

Number two, to look at the question of what do you do in this area? If you look at these sort of maps, which is on page 24, right? If I were to draw, divide Oakland County into quadrants, I took a ruler and measured it, it's true Huron Valley Sinai is the only hospital west. Well, then the question is, does that make sense? Do I want to draw Lapeer County into four parts and put a hospital in each of the four parts? I don't think so. Then you are going to have (inaudible). Under what criteria do you do it?

The way that the sub-areas are grouped now isn't based on an arbitrary question of at least one sub-area for so many people or so many patients, it is based on the statutory criteria, which is the need and the population to be served. The reason why these things clustered out wasn't some magical thing or don't know how, it was because Stan Nash ran the formula and these market share. If the zip codes had more than a 22 -- if my hospital had more than a 22 percent market share in the following zip codes, that was my cluster. If your hospital had more than 22, or in another case, in another HSA, 25 percent of market share in a certain set of zip codes, we clustered those. And where the overlap was, that's where the sub-areas came from. To say that you are going to do this on just arbitrary population doesn't take into account that in outstate Michigan people, by their nature, are going to travel a long distance. So the Munson people are very, very big on not having it by county. In some areas you are going to have sub-areas that are small in population and some that are large. It depends on how they are grouped and where people are going.

The health service area. We don't really need a definition of health service area. This appendix can be thrown out. There is not anyplace in the standards where the phrase health service area is used. For reasons historical, the department has plopped that thing at the end of every standard. We don't use health service area in this question. If we keep on trying to solve all problems simultaneously, you are never going to solve any problems. Since this is a significant net improvement on methodology because it does deal with Peds and OB, it does deal with age distribution, it does deal with (inaudible). Maybe not as much as Mr. Breon is now determining from the population, but at least it moves it forward. You are obligated under your, in terms of sub-areas, your standard says, which is a force of law for you, that you are to determine on page 4 line 173, the hospital sub-area shall be updated at the direction of the Commission starting in May 2003 -- so you told these people to get going fast -- to be completed no later than November of 2003. You are already behind.
It will take care of the questions is there a need for a current hospital to get more beds. All right? That's a significant gain. What I then think you should do is say we had a pilot project for Beaumont on high occupancy. That takes care of the question of a given hospital needs more beds and should not be constrained from getting those more beds because it's in a sub-area with a lot of hospitals that have low occupancy. I dare say that may somewhat apply to Grand Rapids. You should go set up one to look at that and, number two, look at relocation zones.

The standard specifically allows you to make exceptions to the bed need. I would ask you to look at page 6, line 293, bed need. The bed need numbers incorporated as part of these standards as Appendix C shall apply to projects subject to review under these standards. Okay? People are following where I'm at at the moment? Line 293, 294, at least in what came out of my printer. It's Section 5, Sub 1.

But then it goes on to say, except where a specific CON review standard states otherwise. So if in your judgment this is the bed need formula that is good and proper for the current array of hospitals as to whether they should expand, and if so, how and where, but you want to make an exemption for relocation, which you did on a pilot basis for Metropolitan Hospital and you now want to institutionalize it for longer, you want to create some methodology saying there are geographic areas of the state that have a lot of people in them and we decide that nobody -- we shouldn't have more than X hundred thousands of people who live within certain miles that can't get to a hospital within X minutes. You know, something like that. A drive time. That's going to require a great deal of additional work far beyond the charge you gave to this group.
I don't think it is fair to critique this group's work for not dealing with questions you never asked them to deal with. Had hard enough time dealing with what you did.

So my conclusion is to urge you to send it out for public comment, get the feedback, consider the question of whether now or at that subsequent meeting you want to set up a process for relocation of hospitals and population shifts within sub-areas, which is a separate question. And that's the two parts of, Mr. Asmussen can correct me if I'm wrong, that makes sense. You need a separate process to look at that. So at least we make some progress and don't make the perfect (inaudible) of the good. Thank you.

MS.TURNER-BAILEY: Any questions? Okay, I have one more card. Otherwise, I will cut it off. I have one more card. Lody Zwarensteyn.

MR.ZWARENSTEYN: I'm Lody Zwarensteyn, president of the Alliance for Health, and am here to, one, urge that you do adopt the standards in order to take them to public comment and move these along. They have been a long time in development, and I think they deserve the opportunity to get public comment back and then hopefully final action relatively soon. I would like to put a little historical note. The original bed need methodology was commissioned in the mid-seventies by the Michigan Association of Area-wide Comprehensive Health Planning Agency, a body that subsequently I happened to have the privilege of chairing.

The intent was to have a very broad-based group put together a methodology for determining bed needs throughout the state of Michigan. It was done in cooperation with a large number of groups: Blue Cross provided funding, the Department of Public Health then was an active participant, the Office of Health and Medical Affairs, all of the regional comprehensive health planning agencies. The Michigan Hospital Association chaired that group. The idea was to have an inclusive process to allow people to come to grips with the situation of what are our needs in the State of Michigan as far as hospital beds. The methodology was adopted. A lot of the things you heard today were talked about then. Are we going to use geographic boundaries we can draw lines about, or normative areas where you use a percentage of market share. The decision was made to use market share because it is more relevant. The other concept at that time discussed, even before the movie came out, was the notion that some people said if you build it they will come, and other people said no. People are being served. They have preferences. You know, people don't necessarily go to the closest place, they go to what they perceive as the best or the most appropriate. Sometimes that means skipping areas. And the way you capture that is by using the market share analysis that was subsequently adopted. The assumption that just setting a sub-area is going to allow hospitals to build is also going to be problematic. I think there has been a guessing game, gee, if we could really do something in Oakland County we can get a hospital in Novi. Well, I'm here to tell you we need it in Milford instead. Or how about South Lyon? You know, you can do that anywhere. In West Michigan we really need a place in Allendale. Podunk, it doesn't matter. Any area that doesn't have a hospital you are going to define at some time conveniently as needing a sub-area so you can define a hospital if you want for advantage.
The methodology and the way you determine areas is a way of acknowledging population because you are projecting or using a projected population. You are using real movement of people by using the zip code analysis of where people are going. You have the market shares. It is a way of being pretty consistently applied to all of the state regardless of population. If you want a population threshold, you know, you might as well take the upper two-thirds of the State of Michigan and all the Upper Peninsula and make them one area. That doesn't work for anything. The methodology, we think, is pretty consistent and appropriate.
We would like to commend the ad hoc committee and the TAC for continuing the same spirit of inclusiveness that came in the seventies. Everybody was afforded the opportunity to participate. The product that you saw was the product of a lot of people, a lot of organizations. We commend all of them. The question of HSAs, I would like to see you at least recognize that at the time the methodology was adopted the state was actively promoting one

policy that we have consistency in regions rather than have a different region for everybody who' s got a cockamamy idea of geography. Set up a series of regions and allow them to be consistent.
Regions were used for planning and development, economic planning and development, law enforcement planning, health planning, services to the aging. The idea was to allow for some consistency there and also understand that relationships in those regions take time and they do last over time. The relationships of funding, the relationships of participation, organizations, county commissions have a very valid role.
You can say do we need something for acute care? Well, what about mental health? What about other services in the health area? The idea that we ought to have some consistency I think is something that we still should maintain.
I want to recommend leaving the HSAs. There are many reasons for them, and I can go into a lot of those if you would like.
The one thing I do want to leave you with is a memo I sent to the Commission. There is some unfinished work. It deals with the comparative review criteria. There will come a time when you do have to build hospitals. At that time you are talking about scarce commodity, you are going to have to open that up for comparative review, and we are going to need an approach. Right now the pressure isn' t there because the analysis shows there is absolutely no need anywhere in the state for new additional beds above and beyond those we have. But we are going to have to have a way of looking at it.
One of the things that is real disappointing for us is the clamoring for beds in areas that are relatively well served. I don' t see clamoring for beds in innercities or for populations that aren' t served. The economically disadvantaged populations. And you will see those were the intent in the Alliance for Health' s memo to you, recommending comparative review criteria that would get at some real health issues for people that need real health care. Thank you.

MS.TURNER-BAILEY: Are there any questions? Okay, I' m going to ask you, Jan, if you don' t mind, I' m going to have lunch right now because we are very limited on our time that we have for our lunch, and when we come back we will take your comments very first after we break for lunch.
I' m going to take a 30-minute break, a very short break for lunch, and then we' ll return and continue.
The caterer, Davis and Associates, will be providing lunch in this room. So if you want to remain for that, apparently you are welcome to do so.

(A lunch recess was taken 1:10pm – 1:50pm.)

MS.TURNER-BAILEY: Okay, as indicated prior to the lunch break the department has comments that it would like to make, and so, Jan, I' m going to give you the floor.

MR.CHRISTENSEN: Thank you. Can you hear me now? That will be something stuck in our culture for about five decades. I passed out a memo that is coming around. I want to start by expressing my sincere appreciation from the department for the hard work and efforts of TAC and ad hoc committee. They have undertaken a significant task and performed according to their original charge to efficiently update the original bed need methodology, and they deserve our thanks and appreciation. I know they did it with integrity. I know they worked hard.
I had the privilege of running into a couple of meetings and saying a few words. I wasn' t one of those that came out of the woodwork, I did meet with them earlier in the spring and asked them to include wherever possible sufficient amount of rationale and scientific basis for it so that it could be implemented without conflict. And in main, the results of the ad hoc committee and the TAC committee are based significantly on data. They reflect a significant amount of work that the staff and the department has done to help provide the data, run the numbers. And staff has done, I have to commend them as well, they have done a Yeoman' s job of trying to make sense out of the variables and information provided for them. We have one concern, though, that needs to be, I think, developed and it may take a little bit of time to develop that. Develop an answer and adequate response.
We are required under the Michigan and U.S. Constitution, if we develop standards that establish classifications, to establish those on a rational basis. It is a pretty low-level standard. If we can find a good rationale for why a standard was put in place to justify treating different people who are situated differently or who are in different situations, treating them differently, we can do that, we can generally pass court muster on it. And by and large, with respect to the justification of bed need itself, that seems to be pretty solid. There are good variables in there. There does seem to be the rationale.
The difficulty comes, as other speakers today have suggested, or perhaps raised concerns, comes with the sub-area designations. There does seem to be a significant amount of variability in the sub-area designations. And

based on information provided by the staff that were involved, we did rely on market share factors for establishing the sub-area classifications within each area. In each HSA, however, we used a different market share percentage. Or at least several different market share percentages. So in some, such as in HSA-1 and 2 and 6, used a market share of .22. And we used a certain number of iterations to the data to produce the outcome (inaudible) sub-area designs. In other HSAs we used a factor of .25. And in still others, at least in terms of the materials presented in the slide presentation, there was a statement that we used the existing sub-areas because they appeared in judgment to be about right. Now the difficulty with this is that what sub-area you are in and what the characteristics of that sub-area you are in define, in significant part, the unmet bed need in that particular area. So a sub-area that is defined quite narrowly might have a need for a handful of beds, a sub-area that affects a large area may have a need for more beds. And depending on the existing beds, you come up with an amount of bed need for that particular sub-area.

So there is an economic interest that is involved here. If we are going to proceed with a classification system that treats different areas of the state differently, we need a rationale for that classification in order to meet the basic equal protection arguments under our constitution. In order to do that we would need to say, well, we set the market share at .25 because ... and have some reasons for why we did that. We couldn't say, well, let's try it at 25, and does that look right to us yet or are we in agreement that's about right? No, let's try .22 and see how that looks. Or let's try .21. There was a significant component of judgment built into the original model that came out of the University of Michigan, (inaudible) had a significant amount of judgment in it.

That's troublesome if that judgement is not applied uniformly across different classes. You are in effect treating different people in different areas in different ways. We believe that there is a need to do some tweaking and adjustments on the market share factors if indeed the Commission feels that using market share is the right way to go in terms of determining sub-areas. So that we either use the same factor, or if using a different factor in different HSAs, we have some basis and rationale for that. The population is older in that HSA, there are more miles in that HSA, farther distances, there are more poor people, whatever factors that leads us to justification to use a different market share for the clustering of the hospitals. I was unable to find in any of the material any rationale for that basis as to why those numbers are different other than in the judgment of the TAC Committee. And I respect their judgment, they are competent people, but it is a judgment call on their part, not a rational basis for determining it. That's a problem.

And I cite in the handout a number of issues relating to some of the exceptions that were made, and many of those were made based on the judgment of the members of the TAC Committee. Again, these are very competent people, and there is no necessary reason to doubt that they can't make those kinds of judgments, but you need to articulate an organizing principle or rationale as to why they are making that judgment as opposed to this seemed about right, or in our judgment this was about the right size for a sub-area or was not the right size.

We would recommend that we build on the significant work that's already been done and that the Commission send the proposed standards and the bed need numbers out for an independent review with a group of experts in the area of these kinds of designs. Not that we didn't have Michigan-based experts on the committee, but for an independent review to look at it to either help us to clarify or establish the scientific rationale or basis for the classifications that's created in the standards. And we also ask the Attorney General for a review of the sufficiency of the standards in accord with Michigan's rational basis standards.

We want to be able to implement the law if it's passed ultimately by the regulation, if it's ultimately passed by the Commission. In order to do that we have to have a rational basis, at least a rational basis for doing it. And we are not convinced, particularly with the sub-area decisions, that there is a rationale that has been articulated yet why those sub-areas fit together the way they do. Particularly with the significant disparity in the sub-areas in terms of population, size, and even with difference in the market share of why they got that way. We need to articulate that before we can move forward with the standards and before we can implement it.

As the Commission members may know, we are being sued currently for the adequacy of the bed need standard based in large part on is it a rational standard. Is there a rational basis for determining it.

So it is an important issue for us to resolve. We don't think it is an issue that would take a long time to resolve. Given the fact that extreme work that has been done and the framework that's already been crafted by the Technical Advisory Committee and the ad hoc committee, we think we could walk this piece around to some experts and come back with opportunities for the TAC Committee and the Commission to hear from some other experts to decide the rational basis on the sub-area. And with that resolution, I think you would be in a position, then, to recommend it out for public hearing. One other aside. We have available, and we will make available to the Commission members and we will put it up on the web, an in-depth analysis of Michigan's CON program that was done by a group of outside scientists two years ago and has been held up and it was finalized about a year ago. And I'm not quite sure why we were holding it up, but we got it released. And that also provides some input from some scientists, the so-called Duke study that others have heard about. And we are going to put that up on

our website as well for people to take a look at. There might be information there that would be helpful to look at in terms of viewing the rational basis for some of these things.

MS.TURNER-BAILEY: Any questions? Commissioner Sandler?

DR.SANDLER: I have several comments to make. I believe your comments are very appropriate. I personally would support a brief delay.

UNIDENTIFIED SPEAKER: Would you turn on the mike?

DR.SANDLER: It' s on. It' s perhaps one of the few times you wanted to hear what I had to say. I' m sorry if I had not spoken loud enough.
I appreciate your remarks, Jan, and I personally support them. I have some logistical issues that I think the Commission should address. If we go this route, and I would only be (inaudible) relatively brief delay, we should be able to bring this back in March for action.
The problem develops -- in the time I have been on the Commission, the Commission has primarily dealt with bed relocation, new hospitals in west Oakland County, bed relocation, bed methodology. As important as these are, there' s a numberof patient care issues that seems to be put off. Lithotripsy is an outstanding example of that. There is an MRI issue out there, for example. Perhaps the chair should consider -- or I would appreciate if the chair would consider changing the meeting, the number of meetings for next year from four to five now. Because this would take, this is going to take virtually the whole meeting again if you do this. And I have a lot of concern, not with the idea of putting it off, the idea of spending the entire March meeting on this issue and again the patient care issues are not going to be addressed.
So I would ask you to consider either at this date either a special meeting for this or change it from four to five meetings next year or something along those lines, because my concern is if you do, if the Commission chooses to follow your recommendations, this is going to be fairly lengthy again, understandably, there will be a lot of questions, a lot of technical language to explain, and this is not going to allow for other important issues. Thank you.

MS.TURNER-BAILEY: Are there any other questions, comments? Yes, Commissioner Cory.

MR.CORY: I have two questions. You are recommending that it be sent to an outside scientific review team. Number one, do you have a team in mind? Number two, if you don' t, how are you going to go about it? And I guess my third part is you are talking about expediency, you said it wouldn' t take long, how long do you anticipate?

MR.CHRISTENSEN: Let me answer the last question first. I think we could have an adequate review done with recommendations back by the March committee meeting without any difficulty.
In terms of who should do the review, I think that, in part, if the Commission decides to do it, it is a decision-making process that representatives of the Commission or leadership of the Commission, with cooperation of the department, could identify the people who would be available to do that review. I can tell you the people who did the Duke study for us have a great deal of expertise, seen around the nation, have been published in the journal. There may be some individuals there. I can also tell you (inaudible)is doing a review on CON as we speak, and they have individuals and contacts and others and they are taking an objective look at CON. I think there are other individuals who have already made -- experts have come to Michigan to testify in one form or another. I can think of one individual who met with us a month ago who had done similar types of CON reviews in about eight other states.
So I think we could quickly come to a list of people, identify a time in January or February that they could review this material, send it to them, and then have them report back to us what their recommendations and findings are. Particularly with a view --
At the same time, I mean, I think we could ask ourselves about, in terms of staff, about how do we decide a rational basis for what is the appropriate market share. I think we could also get a review from the Attorney General in something less than 30 days. I know they are stressed, but there is a significant amount of case law about the need for a rational basis.

MS.TURNER-BAILEY: Mr. Ball?

MR.BREON: Could I ask a question, please?

MS.TURNER-BAILEY: I'm sorry. Yes.

MR.BREON: Just a quick question. Are you going to be looking at or want to look at just a specific, narrow focus of this or are you trying to reopen this whole thing? Are you just looking at the rationale for the sub-groups or is it the whole thing?

MR.CHRISTENSEN: I think the department, based on our review today, is in agreement that much of what is in the standard and proposed by the TAC Committee is good public policy and can be implemented. We are concerned with the decision-making (inaudible) and the rationale related to that particularly with selection of sub-areas. It just does not seem to be based on the material we have had to review. And our staff put most of those numbers together. We are familiar with them. It does not seem to be that it is a system that avoids classifications. And if it establishes classifications, and it clearly does, that are slightly different from different parts of the state, we need to explain why we are doing that. There needs to be a rationale for establishing that. We are affecting the economic interests of people across the state. People who want to build hospitals, people who want to provide health care, citizens that need health care.

MR.BREON: That's what the experts would be looking at?

MR.CHRISTENSEN: Right. In consultation with whoever the experts are on the TAC Committee. We would bring that stuff back.

MS.TURNER-BAILEY: Commissioner Delaney, did you have a question?

MR.DELANEY: Yes. Jan, so in summary, if we do not undergo a review, independent review that the sub-areas have been determined or sub-area changes have been on a rational basis, that your concern is that there is some risk for liability.

MR.CHRISTENSEN: I think the risks are on three different levels. Whatever changes we ultimately adopt we have to send back to the legislature and the government for approval. And part of their duty is to look at the rational basis standard, and they may well -- and they ask that question, and we need to be able to answer it. To state with some clarity what our basis is for making the differing decisions that appear throughout the (inaudible). The first thing is we are preparing these standards for the people in the State of Michigan and forwarding them on to our oversight committees in the legislature and to the Governor, and we need to be able to answer that question.

The second issue is, yes, indeed, we could be subject to a lawsuit. In the material I handed out, the state of Tennessee, U.S. 6th district, a very recent case, had a law that they passed which created classifications within the funeral industry, and it was declared to be invalid because it set up differing classifications without a rational basis. In that particular case the state health department argued we need this law. We need this different classifications because we are concerned about health reasons, we are concerned about a variety of health issues. But the court said they were not able to articulate the rationale rather than just a declaratory statement, "we are concerned," and weren't able to explain why they were concerned, what the rationale was. And so the court held the law to be invalid.

I don't think we want a circumstance where we move along with bed need methodology, we don't make decisions on it, with lots of providers, and later find out the law potentially is not valid. If we have an opportunity to correct it. Again, I think an enormous amount of work has been done. I think we have a little bit more to go before the goal line, but we also have a standard here that presumably is going to affect us for the next ten years. And if it takes another month or two to resolve it, it seems to me to be a very good investment. I want a law that the department can implement, and for that I need a rational basis.

MS.TURNER-BAILEY: Mr. Ball.

MR.BALL: First let me say I probably agree with Jan in one respect: I think this might be able to be resolved in a relatively short period of time.

This comes as a bit of a surprise to me this morning, but let me comment in a couple of ways. The first is to suggest that there was no rationale for what was done I think would be erroneous. And I'm going to ask Dale or

some of the other members of the TAC to comment on that, maybe even have Stan comment on that. I think that the minutes of our meetings would reflect that this indeed was one of the areas that we looked at greatly. This whole business of the 22 percent or whatever percent and the iterations that were done of data and, you know, how it took place over time. And just because two numbers may differ does not necessarily mean that a consistent rationale wasn't applied to result in those numbers. Again, perhaps Dale or Stan will be commenting upon the fact that what they did was in looking at this market share, run the data until it resulted in a stabilization, if you will. That it didn't result in hospitals moving from one area to another. So they looked at market share and they ran different iterations of the data until the patterns had stabilized, and they stabilized at whatever market share that was. In some areas it might be 22, in some areas it might be others --

Now, if the Commission wants to say, well, let's just adopt 22 or let's just adopt 25 or 28 or whatever, I guess that is your prerogative to do it, but as I understand the rationale that was employed, it was basically run the data until it stabilizes. I think that -- I guess I don't want to use the term observe, but when you have had this many people that are aware of the way that the practice is in Michigan, and so forth, deal with this over such a long period of time, it doesn't seem to make sense to me that you would say, well, let's ask people in New York or Tennessee or Kentucky or someplace else how we ought to do it in Michigan. People in Michigan who are very competent have looked at this, they have looked at the Dartmouth information, they have looked at other information, and they are coming forward with these recommendations. I think if you feel that the background on the rationale of how they were developed is deficient, then the TAC can be clearer, pull the information out of the minutes of the ad hoc, pull the information together in a report, and explain the rationale and provide that to you at the public comment session and at your next hearing. I don't think that it's necessary to send that out to some other body and say, do you think that their rationale was adequate. I certainly wouldn't go to some other body and say what rationale would you use and not provide them information that is available on the rationale that was used by the ad hoc. If somebody wants to come in at the public comment session or at your next session and say, we've reviewed the rationale that was used and here is our comments on that, that's fine. But I would not throw the whole topic open to some other body that is just new to the question and say, well, here is what we think about the general issue. Dale and Stan, I don't know if you would like to add to that.

MR.STEIGER: The only thing I would add is the comment was made that the three or four HSAs in the northern part of the state were -- the sub-areas we are recommending was based on judgment. That's not true. The model was run up there, and the fact of the matter is that the results of the model, the results of the mathematic model, based on patient data, came out that the sub-areas, the sub-area clusters are the same as the existing ones. That's patently different than someone just made a judgment that these are the sub-areas. Things don't change that much up there. They haven't changed, apparently, in a long time. But the fact of the matter is that the model was run and the model produced those kinds of results. The question about the methodology for the sub-areas has been kicked around for the last couple of meetings. I would call your attention to the document that you received in the mail. The last item on the table of contents is a summary of Stan Nash's explanatory comments regarding methodology to designate hospital planning sub-areas. These comments are made on November 5th. I don't believe Mr. Christensen was at that meeting, I don't believe he was at the subsequent meeting, but those questions were asked, Mr. Nash gave a very detailed response which I'm, quite frankly, not capable of duplicating at this point. I don't know that we want to put Stan on the spot, but the point is that the decisions made were very rational.

If you think about the State of Michigan, there are differences around the state, there are different market shares, there are different patient flows, different patient patterns and so forth, and the alpha factors that became part of the sub-area methodology were based on those kinds of issues. So there was a very rational decision process that went through. That rational decision process is documented quite well in both the summary of Mr. Nash's remarks, and we also have the direct transcript of those comments that he made at that time. Thank you.

MS.TURNER-BAILEY: Any questions? Commissioner Sandler?

DR.SANDLER: I would like to make a motion.

MS.TURNER-BAILEY: Okay.

DR.SANDLER: The motion is that this Commission accept the recommendations of the department and that two things be done: The Attorney General's office of the State of Michigan specifically ask for a legal review of the sufficiency of the standard to make sure they are in accord with the Michigan rational basis standard, and send

the proposed standard for an outside scientific review, and which the department and the chair of the Commission decide on who are appropriate experts.
And I wish to add a third proposal, which is -- or third comment which is that this is not a criticism of what occurred today, but it is very difficult for those of us to absorb all of this work in a few days. We really need to get this back to the Commission and out to the public earlier than a few days before the next meeting. That' s not a criticism. I realize how difficult this is. But it is very difficult with only three or four days notice to try to get through all this.
And as an aside -- my motion is over -- this is certainly not a reflection upon the high quality of the work done by the committee. This is simply tweaking this and making sure that we are on the right road. That' s my rationale for the motion.

MS.TURNER-BAILEY: Yes?

DR.AJLUNI: Support for the motion. Dr. Sandler, does the motion end at the first direct foundations and the rest is editorial?

DR.SANDLER: The rest is editorial except for number three that this be sent back to the commissioners and made available to the public ten days prior to the next meeting. That will be the third thing. So we can at least take some action at that meeting.

MS.TURNER-BAILEY: Okay, there is a motion on the floor and it has been -- I' m sorry. Mr. Zwarensteyn?

MR.ZWARENSTEYN: Excuse me just a moment, not meaning to interrupt you, but it is possible to actually advance the timing of this by doing exactly what Jan recommended, but also going to the public hearing and bringing all the input together so that you don' t continually get to here and CON just bogs down, it takes forever and a day to get something through. It seems it would be in your best interest to advance this, to get comments, comments whether from the Attorney General or some good scientists in other states or from residents of the State of Michigan that will be subject to these standard all should be part of your deliberation, so why not move on all fronts, public hearing as well. You know, if you have got the money to buy the experts, fine, bring them in, get the Attorney General, but move this thing along.

MR.DELANEY: Renee, who was that speaking?

MS.TURNER-BAILEY: That was Mr. Zwarensteyn.

MR.MAITLAND: Are we in the discussion stage?

MS.TURNER-BAILEY: Yeah, we are in discussion.

MR.DELANEY: I did not hear the motion. Could somebody just give me a brief summary?

DR.SANDLER: Do you want me to respond?

MS.TURNER-BAILEY: Yeah. Can you just speak loudly?

DR.SANDLER: Commissioner Delaney, the motion is that we follow the recommendations of the department. The recommendation of the department is they expressed concern about some of the methodology that was used on the part of the HSAs. Therefore, they have two items they are asking for recommendations on. The first one is that the Attorney General of the State of Michigan do a legal review on the sufficiency of the standards so to make certain that' s in accordance with the Michigan rational basis standard.
The second is to send the proposed standard for an outside scientific review for a thorough (inaudible) with recommendations to clarify or establish the scientific basis or a rationale for classifications created in the standard.
And Jim, the third part I added, which this has to be returned to the Commissioners ten days prior to next meeting so we can have sufficient time to study this and to act upon it.

MR.DELANEY Here here.

MS.TURNER-BAILEY: Commissioner Maitland?

MR.MAITLAND: I would vote against this motion. And not that I oppose the three items that he has mentioned, but I would add that we send this out for public hearing. I think that's a good opportunity to take input on these three issues. And I believe that the ad hoc probably could provide the information with the rationale that would help us proceed before our next meeting.
You know, we mentioned the Duke report which was supposed to be done in three months, and now it's two years and now you've got it done all of a sudden. You know, that's what's going to happen if we try to do item two and go out for scientific review and all this. And we don't have enough money in the State of Michigan to get outside counsel anyway, probably.
So, again, I would be opposed to this motion, but I will enter a motion immediately afterwards with those three things, plus the fact that we go out for public hearing.

MR.DELANEY: I would be inclined to agree with what I anticipate your motion is going to be, Commissioner Maitland.

MR.MAITLAND: Thank you.

MS.TURNER-BAILEY: Okay, hearing -- yes, Mr. Christensen?

MR.CHRISTENSEN: I'm sorry, Ed.

MR.GOLDMAN: Yeah, I have got a couple of different issues. First, the legal review issue is an important question. We don't want to take a step as big as this without being sure that we have got legal sufficiency. Rational basis is the easiest way to challenge a move like this. So it would be important to get an analysis of whether this has a rational basis. That means going back to work with the Commission that understanding whether there is a rational basis. So I agree with that part.
Part two as written says, send the proposed standards to an outside scientific review committee for a thorough independent review with recommendations to clarify or establish scientific basis or rationale for the classifications created in the standards. It says in the standards. I'm concerned about a scientific review that would say, No, no, do it this way, which would mean we would have to start all over. That would be something that would hold this up.
And my third problem is that we have got state law that says that we were supposed to have acted, what, by October of this year to revisit the hospital review standards and approve or modify. We certainty revisited. We have not approved or modified. We can get close to that by doing what Commissioner Maitland suggests in sending it out for public hearing.
So I am in favor not of the motion as presently stated but in favor of a motion that would look at legal sufficiency, that would do a limited review in the event that the Attorney General believes there is not legal sufficiency. If the Attorney General believes there is legal sufficiency, I don't think we need an outside review. If the Attorney General believes there is not legal sufficiency, then I would be in favor of a limited review to see if we can establish legal sufficiency based on the work that was done. And because I am mindful of the state law and would like to do that in a reasonable time frame, which would at least mean sending what we have now out for public hearing.
And then finally I do agree with the motion of getting material back ten days in advance so that we would have a chance to study it, because this is an issue that would warrant some detailed study.

MS.TURNER-BAILEY: Any further discussion on this motion?

MR.HORWITZ: Madam Chairperson, would you take public comment?

MS.TURNER-BAILEY: I'm sorry. I had your card, Larry. I forgot.

MR.HORWITZ: I would like to support the comments of the last few commissioners. First of all, the statute requires you to consider the recommendations of the department and the Attorney General as to administrative feasibility of legality of proposed actions. So you don't need to go ask him to do something special. That's what they are here for. That's what the gentleman is here for. He is supposed to come and make those comments because he's going to end up having to defend them. Two, the issue that I hear Jan Christensen raising is a

question of why did the TAC have different alpha factors of .22 versus .25 in some sub-areas. It seems to me that the best and quickest way to find out why they did that is to ask the people who came up with the numbers. It would be phenomenally difficult to ask someone from Tennessee or elsewhere, or Duke, why did the people you never talked to do what they did? It seems to me you want to ask them what is the rationale.
They tried very, very hard after Jan Christensen's admonition to document it, explain it. Since it's not Mr. Christensen, lawyer that he is, adequate, ask the TAC people to get together, put together something further responsive. And I'm sure Jan can help them on exactly what his concerns are. Send that to the Assistant Attorney General and have that information presented at your public hearing. What I'm concerned about the outside experts, if you ask an outside expert a narrow question, most outside experts I have ever bumped into tend to broaden the question and lengthen the time of their inquiry. We were constrained in doing all this because the department didn't have the money to provide the staff on an ongoing basis for it. And I know the department is under other economic constraints. This is just going to prolong it greatly.
So I would like to suggest that send, adopted it, (inaudible) for proposed action. Send it out for proposed hearing. Ask the Attorney General to consider the more detailed comments by the TAC as to why .22 and .25, and clearly make it that's the narrow issue, the one issue that the department identified. Have that presented at the public hearing. That can be a time when Commissioners can come and listen. And we move this thing forward. Because I do agree with Commissioner Sandler, the CON process is supposed to be dealing with more than just acute care hospital beds where they are now and where they might be tomorrow. Then we can move this thing forward.
If the department in its judgment wants to hire ten experts from wherefore they want to in the world, that's their independent judgment. They can do that if that's what they want to do.

MS.TURNER-BAILEY: Thank you.

DR.SANDLER: I would like to call the --

MR.CHRISTENSEN: Madam Chairperson?

MS.TURNER-BAILEY: He's trying to call the question.

DR.SANDLER: Go ahead.

MR.CHRISTENSEN: Let me say that I did ask the CON staff, in extensive meetings, how the numbers cranked out differently in terms of market share. I did take a look at their background data reports. I did, as recently as yesterday, ask for confirmation and got that in writing from the staff that the numbers are different. I have no doubt that judgments were made about why those market share numbers were different. But the judgments varied between the various areas that are affected. So if it was in this area, collectively the judgment came down one way. If it was in a different area, collectively the judgment -- and all in good faith. I'm not being critical. I think they took their tasks very seriously to update the market share methodology that Griffith gave us some many years ago. We are going to have to thank him for it.
But the truth of the matter is we did come up with different classifications, and there is no articulated response as to why those market shares are different and how that relates to some intrinsic variable in that community, whether aging population, health care needs, distances in travel. When we set up a definition with this Commission on rural, which you passed earlier today, and we set that definition up, it's based on population density. And so when you apply it, rural means rural. Regardless of where it is in the state, it's the same definition. It is not rule .25 in this area and .22 in that area, and .21 in that area. The two HSAs for which the existing configurations and the sub-areas were made, the numbers there appear to be .28 and .30. So based on the previous work papers that were run through the Technical Advisory Committee. So we have numbers of .22, .28, .3, .25. It's a problem and it needs to be addressed. I don't believe outside experts are the kinds of people that we have to listen to everything they say, but I think sometimes when you have a committee that has worked very hard on something a long period of time, it doesn't hurt to get an outside opinion, and it's called a second opinion and it's pretty good. We don't have to accept it. The department doesn't and the Commission doesn't. But getting a second opinion gives you another piece of information.
I would speak against anything that would delay us from having an opportunity to consider possibly this standard in March because I think we can reach the conclusion we need to in that time. And I'm mindful there is a time frame for concluding the bed need methodology. So I support a quick review of it. I think there is value to an

outside review. I urge the Commission to endorse that. You don't need to accept it if you don't like the answer you get, but it does give you another piece of information to consider.
None of the folks on the Commission served on the Technical Advisory Committee or ad hoc committee. So you are relying on their point of view and input on this. And it's a good point of view, and it's a reasoned and good point of view. I don't want to alienate any of my colleagues on the Technical Advisory Committee. I think they did about as good a job as they could under the circumstances. I do think we have some problems to fix.
If we send it out for review for public hearing and you get comments back in and you make changes, we are going to go out for another round of public hearings after March. If we fix it and send it out, we can get it on a very short time frame, and perhaps the extra meeting that Dr. Sandler was talking about.

DR.SANDLER: I have a motion to call the question, please.

MS.TURNER-BAILEY: We have a motion to call the question.

DR.AJLUNI: Support.

MS.TURNER-BAILEY: Support. All those in favor raise your right hand. Five. This is calling the question. Just calling the question. Okay, can I count those votes again? Okay, eight. Okay.

MR.DELANEY: Was that Dr. Sandler's motion?

MS.TURNER-BAILEY: No, that was a vote on the motion to call the question, Commissioner Delaney. Do you have a nay or a yea?

DR.SANDLER: This is just to call the question.

MS.TURNER-BAILEY: Just to call the question.

MR.DELANEY: The question as to whether we --

MS.TURNER-BAILEY: To close debate.

MR.DELANEY: The question is whether we vote on the motion, yea.

MS.TURNER-BAILEY: So there is a motion on the floor. Dr. Sandler's motion which has been supported, three part motion which supports the two department recommendations and adds that any changes be returned ten days prior to the next Commission meeting. All those in favor please raise your right hand.
We have got three in favor. Mr. Delaney?

MR.DELANEY: No.

MS.TURNER-BAILEY: He votes nay. Three in favor, so the motion does fail.

MR.MAITLAND: I move that we send this out for public hearing. That we ask the Attorney General's office specifically for their review, which I thought we always got anyway, and that we try to get this information back to us at least ten days prior to our next meeting date.
As per item two, I agree with Mr. Goldman that while Mr. Christensen -- they can do anything they want. If they want to go out and get a review, they can. But I don't think we need to support that, nor do I think it is necessary unless the Attorney General says we do not have a rational basis after talking with the technical committee. So, so moved.

DR.YOUNG: Support.

MS.TURNER-BAILEY: And it has been supported by Commissioner Young. Discussion? Commissioner Hagenow?

MS.HAGENOW: I want to ask Jan why he wrote specifically, including sending it out for public hearing. What was your rationale for why you said don't send it out for a hearing?

MR.CHRISTENSEN: You could certainly go ahead and send it out for public hearing. I think there are two drawbacks for that. One is you will undoubtedly collect, most likely will have two sets of public hearings (inaudible) and it's a matter of economy. If we fix the language to the point the Commission is happy with the language and we have assurances that it meets rational standards review and then sent it out for public hearing, we are more likely to get back a response that we can adopt. If you send it out for public hearing, we will get a number of comments that won't be unlike the comments you got today, and then it's a question of distilling all of those comments together and having the committee consider all of that in addition to the legal sufficiency arguments.

I think we can avoid that by making the adjustments at this point in time and then sending it out for public hearing. But that's a matter of preference. If the Commission feels it wants to conduct two public hearings on it, that's an okaything.

The other drawback is if you send a standard that lacks legal sufficiency or rationale out for public comment, you are also sending it to the legislature and you are also sending it to the Governor and providing them notice that you sent it. And you have a review conducted at that level, which, if there are problems, and I believe in terms of our departmental review there are problems, those groups will recognize those problems and present those problems back. So you encourage a certain amount of work on their parts to review problems you already know are available. Unless the transfer note that you send to them is: We sent this out. We know it has problems. We are working to fix those problems. But it hardly seems to be the preferred course.

MR.DELANEY: Ms. Turner-Bailey, this is Commissioner Delaney. I'm afraid I have to excuse myself.

MS.TURNER-BAILEY: We are going to take a vote in just one moment, Commissioner Delaney. If you can give us another minute I think we are at the voting point.

MR.MAITLAND: One more comment. Under my motion we might possibly get this done at our next meeting in March. We might not, but it's not going to be any longer than if we wait until next March to decide whether we are going to proceed. So this is the only way we can possibly speed up the process. I'm not trying to eliminate any information.

MS.TURNER-BAILEY: There is a motion, it's been supported. All those in favor please raise your right hand. And Mr. Delaney I will ask you for your verbal vote. Five. Mr. Delaney, your vote is?

MR.DELANEY: Aye.

MS.TURNER-BAILEY: Six votes. And the motion carries. Thank you very much everybody for your -- yes, Mr. Ball, you have a question?

MR.BALL: Yes. I think as a logical follow-up to this -- Dale was asking me, you know, what happens now. And, I mean, for the Attorney General to make a review, I would suggest that the commission director suggest to the department, A, that Stan provide the write-up on the process that was used. And again, while Jan says that he has got input that it was an inconsistent process, everything we've heard today was that up to today was that it was a consistent process. So I think that we need a write-up from Stan, and then I think the representative of the Attorney General's office needs to meet with the TAC to have a full discussion of that before he or she can render an opinion.

MS.TURNER-BAILEY: I think that's an excellent suggestion, and I would hope that he would want to do that in any case, but I certainly will ask him specifically to get that input as a part of his judgment. Thank you.

DR.SANDLER: Madam Commissioner?

MS.TURNER-BAILEY: Yes.

DR.SANDLER: I have a point of personal (inaudible). As I said, I have to leave. I want to wish everybody a happy holiday season.

MS.TURNER-BAILEY: Thank you. Thank very much for your participation. Lithotripsy.

MS.ROGERS: In your packet today you do have some proposed language regarding the lithotripsy standards. Basically this language was put together based on the public testimony that we received at a prior public hearing as well as subsequent written testimony following that public hearing. And we have also taken into considering checking with the staff within the CON section to review these standards. So those were involved as well.
So what you have in front of you today is language that you can either take proposed action on, if that's your decision, or take any other action as you deem necessary, whether that's sending it out for a standard advisory committee or some other outside entity.
Also to let you know we have included the new rural definition in this language as well as the micropolitan and metropolitan language. That has been incorporated in the version you have before you today. I can go through each of the changes if you would like after you have had a chance to at least take a summary review. So, you know, or if you just have questions. And Dr. Goldman -- Mr. Goldman was the liaison for these standards. And if you have anything to add specifically, feel free.

MS.TURNER-BAILEY: Commissioner Goldman?

MR.GOLDMAN: Yeah, I was happy to be asked to be the liaison. I have looked through this carefully. And there are two major issues. One is (inaudible) lithotripsy, kidney stone treatment centers and the other is some updating of some of the technical criteria. (Inaudible) -- is moving from an inpatient to outpatient service increasingly. And that is because of the change in technology. So if you remember, the earliest machines were water bath machines that had to be used internally. That has since changed.
There are some technical questions because of moving from inpatient to outpatient about conversion factor, whether we should use ICD-9 codes or CPT codes. I think those issues can be adequately discussed at a public hearing.
I believe that the language as presented today is sufficient for us to pass it, send it to public hearing, and get it back at our next session to take final action, because I believe that the only issues left are a couple, as I say, of technical questions. I would recommend that the Commission take that action because I think this is one of those areas that, as Commissioner Sandler pointed out, has been sort of lost in the shuffle as we get new work and as we look at bed need methodology. (inaudible) -- services, this is one of those areas where we need to be mindful both of need and of access the way (inaudible) been going with mobile lines there is increased access to people without necessarily increased costs. So based on my review I would urge that the Commission move this forward. And I'm happy to respond to any questions.

MS.TURNER-BAILEY: Thank you. Are there any questions? Don Pietruk? I'm sorry, Don, before you get started. Brenda, was there anything in particular you wanted to call out?

MS.ROGERS: Yes.

MS.TURNER-BAILEY: I'm sorry. I should have let her speak first.

MR.PIETRUK: That's fine. I'm willing to wait if Brenda wants to do a presentation.

MS.TURNER-BAILEY: Thank you. Just give me one moment and I'll call you back. Thank you.

MS.ROGERS: This is just a technical note. If you look at the language under Section 4, the new Subsection 6 with regards to CKSTC. We have included in there ICD-9 codes that were provided subsequent to these standards being drafted. There were a couple of minor changes to those ICD-9 codes. So if you do move these standards through today, I would just like to make a recommendation to these changes if you see fit.
The ICD-9 codes for cystoscopies, we would remove 57.0 and replace that with 57.33. Excuse me. That's already there. So just remove 57.0. And then under the ureteroscopies -- I'm probably pronouncing that wrong, but ICD-9 codes 56.3 should be 56.31. So I would just recommend those changes if you move those forward today.

MS.TURNER-BAILEY: Are there any recommendations you want to call out? Okay, are there any questions for Brenda? Okay, Don.

MR.PIETRUK: Good afternoon, Madam Chair and members of the Commission. Thank you very much for allowing us to address these issues. I'm Don Pietruk. I'm representing United Medical Systems today. As you are aware, we have been asking the Commission for probably over a year to have a look at the litho standards. And we understand -- you know, we kind of feel -- we are glad the 800-pound gorilla has gotten off the block for a few minutes. Anyway, we just want to say we are very supportive of the standards as have been promulgated to you by the department. In particular, the one change that we wanted to see made was to allow for expansion of existing services that are working at very high levels of operation, roughly over 2,000 procedures, to be able to add another lithotripter to their mobile routes. We also feel that the department has adequately said that those machines have to be performing 1,800 procedures and project 2,000 over a two-year period, and we are fine with those changes as well. And so we are asking the Commission to approve the changes in these areas that have been forwarded by the MDCH staff.

We do have one concern. That's the language that creates this new entity called the comprehensive kidney stone treatment center in the standard. And this would allow those with the fixed lithotripter that are operating to replace itself if they are doing 200 UESWL procedures and a combination of 2,000 other procedures, including cystoscopies, ureteroscopies, and nephrostolithotomies.

UNIDENTIFIED SPEAKER: Gallbladder.

MR.PIETRUK: Thank you. The concern we have is that the 200 number of UESWL procedures is extremely low. That essentially represents one full day of operation per week at a fixed lithotripter. We feel this kind of goes against the rest of the standard, which was encouraging low performing fixed lithotripters to band together and form mobile routes. So we feel this is kind of a contradiction in the standard, the proposed language. It contradicts some of the earlier effect of the standard.

If this had been in place in the current standard, this would have allowed -- as we know, two hospitals in Detroit combine their fixed lithotripters in a mobile route. Under this language, each of them could have kept their fixed lithotripters and not served, you know, been serving a much smaller number of patients than what they are now. So we feel that the language which has encouraged cooperative ventures has allowed better service to the patients in the state and we feel this trend should be continued. We would ask the Commission to either remove that section of the standard for public comment or -- we feel at the very least some drastic changes need to be made to it. The number of lithotripsies, if those fixed units we understand are maybe serving regions of the state that don't have as much mobile service, if they need a much higher number to replace themselves, that's something that could be looked at and maybe some more stringent requirements put in on those fixed centers to qualify before replacing them. Perhaps having to do kidney transplants or things such as that, things of that nature.

With that I will conclude my comments and be happy to answer any questions.

MS.TURNER-BAILEY: Are there any questions? Can you just tell me again -- you started out by saying I support the language, but then --

MR.PIETRUK: We support everything -- the only thing we don't support is the comprehensive kidney stone treatment language as written. Everything else in the standard we support. So we would ask that that language -- we feel that language -- strongly feel that that language either needs to be stricken out or modified drastically.

MS.TURNER-BAILEY: Okay. Any questions?

MR.BREON: Well, I don't know if I have a question, but I might have to state a conflict because we are one of those fixed site centers in Grand Rapids. I would disagree with some of his comments. I think I better at least state I have a conflict of interest in this particular case.

MS.TURNER-BAILEY: Commissioner Goldman, could you comment on this area?

MR.GOLDMAN: The area is found on page 6. It is section 4.66. It actually refers to the definition of a comprehensive treatment center, which is on the first page. The notion is that kidney stones are dealt with in a number of ways. One way is shock waves, which is UESWL. The second way is a laser approach. The third way is endoscopy or other stone retrieval or cystoscopy.

Then on page 6, Section 4.6 defines the number of procedures that a comprehensive kidney stone treatment center would have to accomplish. And it says at least 2,000 treatments. And then the part that the speaker was dealing with says of the those 2,000 at least 500 must cystoscopies, 400 nephrostolithotomies, 300 ureteroscopic procedures and 200 UESWL. The argument, as I understand it, is that the 200 UESWLs is too small a number. As I understand the drafting, the notion of a comprehensive center says that you have to be doing 2,000 procedures. That's a lot of procedures. And it breaks down what percentage have to be in each of the following areas. And the notion there, as I understand it, is the notion that this Commission has seen before, which is in order to maintain quality, you have to do at least a minimum number of procedures.
I haven't seen the data that you referred to, but it is certainly possible that a 200 number two facilities could keep a fixed machine active. I think the only place that there are two fixed machines now is in the greater Detroit metropolitan area.

MR.PIETRUK: Yes. There is one outstate. There is one in Grand Rapids and two in southeast Michigan. Two fixed machines in southeast Michigan and one in Grand Rapids.

MR.GOLDMAN: Right, but the only place where the issue that you raise would be a problem is with those two machines.

MR.PIETRUK: Potentially, yes.

MR.BREON: There would definitely be a problem in Grand Rapids when it comes around to place a (inaudible) machine.

MR.GOLDMAN: But the issue that he was describing is two fixed machines in close proximity to each other.

MR.BREON: That would not be a problem.

MR.GOLDMAN: That would not be a problem in Grand Rapids or in Washtenaw County, but it could be a problem in the Detroit area.

MR.PIETRUK: It could, yes. I think the other point I was making is that the 200 number is(Inaudible) so some regional centers outstate may have problems meeting a thousand at this point, the 200 number, that's a big difference. 200 and a thousand is a big gap is what we are saying.

MS.TURNER-BAILEY: Okay, any questions? Okay, I have one more card. Robert Meeker?

MR.MEEKER: I'm Bob Meeker from Spectrum Health in Grand Rapids and I have- I have nothing to say. (microphone squealing. Laughter.) Yes, my magnetic personality. I would like to put my comments in the context of the previous two sets of standards we have just considered. This morning you reviewed, I think, substantial changes to the CON standards for CT scanners for which there was essentially universal agreement. They were approved with little comment for public hearing last time. They were approved as final standards today with little comment.
At the other end of the continuum would be the acute bed need standards which had lots and lots of discussion, lots and lots of disagreement, and that was after going through a very rigorous committee process. Whereas the CT standards went through no committee process but rather were recommendations made directly to this body, which is entirely conceivable within the current law. I would contend that the litho standards kind of fall somewhere in between. They are certainly not as clear-cut as the CT standards, nor are they as controversial as the acute care standards. But I do think there is some areas of disagreement. And I will certainly accept ownership of some of the language that was used to define specifically the comprehensive kidney stone treatment center. I would view that as -- and it was certainly done in consultation with experts not only within our institution but also across the state. I would still view that as a beginning step. And while I may not agree with Mr. Pietruk's specific challenge about that one particular number, I think that that concept probably deserves further review. I think that there are enough areas within these standards that are not readily agreeable, that there are not only difference of opinion but more work needed, that perhaps this would be an opportunity if not to use a formal standards advisory committee, at least have some sort of a professional group, including not people like me who are planners who consulted with urologists, but perhaps a few urologists. I think you would need coding experts to look as the ICD-9 codes, because I do think that there might be some coding issues as well.

In talking to some of the other lithotripsy centers across the state, when they do outpatient lithotripsy procedures, which is virtually all of them, they don't use ICD-9 codes in their coding process, they use CPT codes. And there is not a one-for-one conversion from one to the other. So if you define only using ICD-9 codes, it is very difficult for another center to demonstrate compliance.
So I think the whole definition of the comprehensive kidney stone treatment center is a good start and could benefit from additional review.
I think there are other aspects of these standards that need to be looked at. I think that the formula for determining the need for lithotripsy services is woefully inadequate. It is based on -- currently based on inpatient data with a conversion factor. In the current standards the conversion factor is .7 something. And the department has re-examined this and is recommending a .8 something.
Lithotripsy is almost predominantly an outpatient service. And so the discrepancy between inpatient data and outpatient services is problematic. Now I understand the reason for using the inpatient database is because it's the best database we have got. And we have faced this in other standards historically, such as MRI. I'm not necessarily recommending abandoning the inpatient formula, but I do think that the factor rather than being a fraction should be greater than one, perhaps even greater than two. And I think that data that Henry Ford and United Medical Systems has submitted to this Commission in the past indicates that for the sites that they serve, the conversion factor is something in the neighborhood of 2.6. In other words, calculating the inpatient data at a particular hospital and then calculating the number of lithotripsies done at that host site, it's not a fraction, but rather it's a multiple of two and then some.
So I think that formula deserves careful reconsideration. And certainly not something that I would expect you to do, and I'm not sure it's appropriate for a public hearing situation as well. In talking about the comprehensive stone center, there are other nonprocedural aspects of being a comprehensive stone center. Everything that you've got an ICD-9 code for here are procedures. They may not be surgeries, but they are -- we're manipulating something.
Many kidney stone cases are also treated medically. And perhaps including a definition and perhaps some way of measuring the total volume of a comprehensive kidney stone treatment center, because that's what we are talking about here. In many ways lithotripsy is a very small part of that. So including the medically treated patients as well as those who are treated by cystoscopy or some of these other unpronouncable procedures.
Finally related to mobile routes, I think that more -- you have proposed language to allow existing mobile routes to expand. And I certainly think that that's a worthy avenue to pursue. I would suggest that perhaps if the formula were changed, the inpatient formula that I mentioned a moment ago, that might serve the same purpose.
But some of the other comments that were received in public comment relate to the requirements or the obligations on the mobile providers. Mobile providers, who rather than serving at many different host sites perhaps once a month, might be obligated to have a more frequent schedule so that stone patients aren't required to live with their kidney stones for two or three weeks until the lithotripter comes back.
I'm not a lithotripsy expert. I think about that in terms of being a patient who up until now has never had a kidney stone, but that's not the kind of situation I would want to have to wait for the machine to come back, you know, two or three weeks hence. I'm sure there are differences of opinion on that statement as well, and I think that all of these would benefit from the scrutiny that a more professional group could give it and not debate that here and in public hearing and then back at this forum again.
So I would urge you not to pass these standards for public hearing, but rather to refer them to some sort of an advisory group for additional, professional input.

MS. TURNER-BAILEY: Thank you. Are there any other questions? Are there any questions? Ann -- I'm sorry, I can't-

MS. MITCHELL: Mitchell. Good afternoon. Thank you so much. It has been a long time. I'm glad that you are able to listen to us today. We have been trying since early September to address the Commission on an issue that has been near and dear to us, especially treating the patients on this mobile route (inaudible) lithotripsy corporation.
If I can do it, this is not rocket science. I think what we had been forced to do within the standards, and in obeying all the rules, was to formulate a plan within your given standards to consolidate and deliver service to a greater population. And what we were able to show since November of 2001 is that those two lithotripters that were situated in fixed positions in Detroit were really more valuable to serving the actual need of a thousand cases each out in the community, and that's exactly what we have done. In essence, what we are really asking for is to deliver service based on that one standard - 1,000 cases in a mobile environment. We can do it this way. It's not fair to the patients.

The other thing that I wanted to address as well is I saw that, just like Bob said, the inpatient data does not reflect what we have found in the last year. Even remotely. The comparison just doesn't quite do it. We were in a unique position to use the MIDB data directly from the hospitals that were virgins of lithotripsy and then did compare that against the actual number of patients that were treated at each of those facilities and came up with a factor of 2.6. So it was a lot different. I don't know if it is based on the communities where we are serving or what exactly it is. I don't believe that we are treating anything that isn't supposed to be treated. And I don't think we have adversely affected any of the numbers anywhere else, from what I understand. I'm not exactly sure what that all means. But .8 might not be the appropriate number as well. The other thing I wanted to try to better understand in the language where the kidney stone centers are addressed are the statistical relationship between cystoscopy and kidney stones. I don't know that that is an appropriate, necessary measure of defining who is going to have a kidney stone or not. And I think that an expert is probably a good idea.
I think that 200 -- on other mobile service route we serve mobile service host sites at this current time. A number of them do 200 cases per year. And they get service once every other week. Two days per month. And that doesn't seem like an adequate number, based on Certificate of Need, because I think that every single hospital of a certain size could do 200. I guess that's all I have to say. Thank you.

MS.TURNER-BAILEY: Okay, are there any questions? Okay, thank you. I have been told our court reporter needs just a short break. Barbara Jackson, you are going to be up as soon as we come back from the break.
(A brief recess was taken.)

MS.TURNER-BAILEY: Barbara Jackson.

MS.JACKSON: Here.

MS.TURNER-BAILEY: Okay, we are going to get started again. I'm going to give the public notice in advance, we do have several commissioners that have a very strict time limit of 3:30. So we are going to try to get to those voting issues before 3:30. There are still other non-voting issues that are on the agenda that everybody is welcome to stay as long as they want to. But I'm asking for everyone's indulgence relative to time. Thank you. Barbara?

MS.JACKSON: I will be very brief. I'm Barbara Jackson from the Economic Alliance for Michigan. And yes, we very much support updating these standards. We think it's very important to look at these. We applaud those folks that have consolidated, you know, lithotripsy services and consolidated the services in the areas.
We think, based on the many complexities that have been identified today and in the past, that we would strongly urge having this go to an advisory committee. But we think it needs to be addressed and we strongly support that. Thank you. Any questions? Thank you very much.

MS.TURNER-BAILEY: Thank you. Are there any further questions, comments on the lithotripsy language? Is there a motion relative to the lithotripsy language? Commissioner Goldman?

MR.GOLDMAN: Since I was asked to be the liaison, let me move that we move these to public hearing. That at the public hearing we specifically ask that people make comments about the adequacy of the conversion (inaudible) codes, CPT versus ICD-9 and the other factors that have been ably brought up by our speakers today. That material can be returned to us at our next meeting. If it turns out that there are technical corrections that need to be made, those can be made and we can proceed. If it turns out that this is more complex than we presently realize, we could at that time create a committee.
My sense was that we not -- that we may not need to do that. I could be wrong. Bob Meeker and Barbara could be entirely correct, but I would make a motion that we approve this on a preliminary basis, send it to public hearing, and then based on how the public hearing comes out, we can then decide whether to proceed to final action or not.

MS.TURNER-BAILEY: That's your motion. Is there support?

MS.HAGENOW: Support.

MS.TURNER-BAILEY: Support by Commissioner Hagenow. Any discussion? Brenda.

MS.ROGERS: Does that also include just the couple minor changes I made on the ICD-9 code?

MR.GOLDMAN: Yes, of course. That motion would include the changes that Brenda mentioned today to correct the two ICD-9 codes.

MS.TURNER-BAILEY: Okay, thank you. Any further discussion? All those in favor show by right hand? That's what, how many is that, seven? Okay.

MR.MAITLAND: What do you do when you look out that way if you don't count?

MS.TURNER-BAILEY: I was looking at Commissioner Breon.

MR.BREON: I have a conflict.

MS.TURNER-BAILEY: I wanted to make sure he hadn't actually voted. So that will go to public hearing. I guess we should think about whether or not that should be a separate hearing from the rest of the -- so if it is a group hearing going on with the other minor technical issues, because this one sounds like it is a little bit more complex and we will need more time. So we will set up a separate one for lithotripsy from the other rural micropolitan, et cetera, et cetera. Thank you, Mr. Goldman, for your work as liaison for this issue.

The only other thing we really need to have a vote on is the work plan, right? Everything else is just review. So can we skip to that now so at least we will know we have those things completed before anybody has to leave? So if you will look behind the tab on the work plan. Brenda, I will ask you to go through that.

MS.ROGERS: All right, on the current work plan we have going out for public hearing several standards, air ambulance services, bone marrow transplantation services, cardiac catheterization, computed tomography, heart, lung and liver transplantation services, MRI services, neonatal intensive care, nursing home, open heart surgery, pancreas transplantation services, positron emission tomography scanner services, as well as lithotripsy services. In addition, and this is going to tie right into the MRT and surgical update, and that way you will be able to bypass those two on the agenda. MRT we are currently compiling the public hearing comments and working on those standards, and hopefully in the near future we will be working with the liaison on those standards. And then surgical still remains on the work plan. And that will follow MRT at this point.
New medical technology remains on the work plan. We still have on the work plan the sections requiring CON Commission action based on PA 619. And if you will note in your binder the materials under the miscellaneous tabs there is an updated chart in there that shows if the action's been completed or is in process or is on the work plan. So hopefully that will be, that's for your information, for guidance.
And hospital beds remain on the work plan as well for the future work we have to do on that. I think that's everything.

MS.TURNER-BAILEY: Okay. Thank you. Are there any questions? Let's see, I have Larry Horwitz.

MR.HORWITZ: I just want to quickly follow up with the substance of the testimony I made before. Urge the Commission to put on its work plan the question of exceptions to the bed need standards. As I mentioned, the bed needs standard covers everything except when you want to make an exception. You made an exception -- there are three areas that seem to me to be relevant. One is high occupancy, which you made to take time limited exemption, which you had said you would then revisit it when that report comes in. I don't know where that report is.
Two, you made an exemption of relocation of a hospital outside the two-mile area. You let Metropolitan go ten miles. Right?
And then the other -- I'm sure there are three. Somehow I counted myself three. And one is starting a whole new hospital. All right? Which you are called upon to deal with under Section 221510 of the statute says you are supposed to do this and consider this question. Oh, the question is what about this question of -- my third is what about the question of an area, large area that has lots of people in which there is no current hospital. Under the bed need methodology they wouldn't be a separate sub-area and how are you going to consider dealing with that. Mr. Breon asked does that mean there never could be a new hospital.
Those are the three things that the bed need methodology, as such, can't deal with, isn't structured to deal with. Do you want to continue the two exemptions you already made or do you want to deal with the question of an

open area of a new hospital? That way you could have a forum in which people could come and air their issues and air their concerns and see if we can make progress on the other one without simultaneously contangling it with the sub-area question.

MS.TURNER-BAILEY: Thank you. Any questions? Mr. Maitland?

MR.MAITLAND: If we do an advisory committee, do we have to do a charge similar to what we did before? Is a charge still required?

MS.TURNER-BAILEY: Do we need a charge? If we put together an advisory committee, do we have to do a charge similar to what we did with ad hoc?

MS.ROGERS: I don't believe there is anything specific in the statute that requires a charge, but I guess it would just be probably good advice that if you are going to create a committee that you give them a charge to work with so that --

MR.MAITLAND: I meant a formal charge.

MS.ROGERS: I guess that would be my recommendation. Certainly that's your prerogative.
Renee, before we move on, if I could just point out, the question was brought up, one of the things was the metropolitan language that expired. In case you didn't see it in the hospital language that was given to you today, one of the changes in there that are being moved forward to public hearing is the striking of that language because it has been -- has expired.
Along with that, if you look at the comments, we did provide a brief report on what was required under that portion of the standard. And basically there was only one application that was received and approved with a total capital expenditure of 141,596,928 billion dollars -- million. Excuse me, million. The projected cost savings to be realized were estimated at just over 4.9 million, and the cost savings information was provided to the regional review agency. Just for your information.

MS.TURNER-BAILEY: So they spent 141 million and saved 4.9 is what you are telling me?

MR.MAITLAND: Are we done?

MS.TURNER-BAILEY: No. I have one more card. Amy Barkholz?

MS.BARKHOLZ: Hi. I'm Amy Barkholz from the Michigan Health and Hospital Association. I want to ask if as you are considering the work plan you will put the issue of MRI standards on the work plan this time for consideration at the March meeting. You might remember that in September a number of hospitals submitted testimony and came to testify about the issue of communities that currently have no fixed MRI. There is proposed language that the Michigan Health and Hospital Association board have supported which would allow a slightly lower volume threshold for small or rural communities that aren't currently served by fixed MRI's. This is a good starting point.
We have talked with the Department of Community Health, with the Economic Alliance, with a number of other folks who are at least supportive of moving forward to talk about this proposed language. I know that Commissioner Sandler had to leave early, but we spoke with Commissioner Sandler about this. He is willing to act as a liaison like you have done in the past with some other issues to work with us in the few months before the March meeting to see if we can get this proposed language that we submitted in September in a format that would be appropriate for you to consider at the March meeting.
So I would just ask if the Commission would allow the MRI issue to be placed on the work plan for the March agenda. And if we are able to get interested parties together to review this language, we may have some proposed language for you all to consider. Any questions?

MS.TURNER-BAILEY: Okay, any discussion? Any further discussion on the work plan? Is there a motion relative to the work plan?

MS.HAGENOW: I don't knowfiit is a motion, but I think we should put this advisory group together for the change, the exceptions, the models that need to be observed and what happened with them, the two-mile rule,

when would we decide that a new hospital with population shifts was in order. Those questions are going to hang out there irregardless of what happens with the bed needs, so that we get that started. I don't know if I am saying it even all right, but it's all those little loose ends that I believe we should recommend and charter, and somebody should get together and come up with the exact wording of the questions that we want answered.

MR.CORY: Support.

MR.BREON: I would like to support what Amy just mentioned about MRI's and rural hospitals, too. I would like to see that on the work plan as well.

MS.TURNER-BAILEY: Commissioner Hagenow, you want to make an motion about the work plan?

MS.HAGENOW: I think, yes, that both, the MRI and that we charter, we ask for you to take these loose-end questions, put them into some type of draft that we can approve and we charter an advisory group for the issue of the outstanding issues of observing the outcomes of the models, the two-mile rule, and the conditions under which we would put a new hospital into an area.

MR.HORVATH: Are you asking that the department prepare a charge for the March meeting, and then from the March meeting if that charge is approved, then you will develop a standard advisory committee?

MS.HAGENOW: I think with the amount we have on our agenda, that would be reasonable in terms of the speed with which we are going to get it done. Yeah, I would be okay with that. Add the MRI on the work plan.

MR.BREON: Is that something that can be done in March or is that something that needs to be on the work plan and then have future discussions?

MS.HAGENOW: The MRI?

MS.ROGERS: Well, I believe that is already on the work plan from the September Commission meeting, so it is just a matter of prioritizing which of these standard you want completed first.

MS.TURNER-BAILEY: Right. We already have MRT and surgical services underway. We need to -- I think we should put MRI on the list. Which means we need to get a liaison and get the language together. I don't know if we can guarantee that we will be looking at the language at the March meeting. Because just limitation and resources I think is going to become an issue.

MR.HORVATH: Would you like the department -- Amy suggested, I believe there has been some discussions with Dr. Sandler; would you like the department to see if you would like to add that to the liaison on the MRI issue?

MS.TURNER-BAILEY: Sure.

MR.BREON: Since he is not here.

MS.BARKHOLZ: He said it was okay, he would do it. He said he would do it.

MS.TURNER-BAILEY: So if that is an adequate compromise that we will go ahead and establish the liaison to work with the department who I assume will be working with MHA and others to get that language together. And as soon as we can get it on the agenda, we will. I don't think we can guarantee that it will be on the March agenda. At this point. Go ahead, Amy.

MS.BARKHOLZ: I understand what you are saying, and I agree, other than -- I understand that you say you may not be able to take proposed action in March, but I would ask that it still be placed on the March agenda.
A few points that I probably should have made is some of the hospitals that were here testifying in the September meeting -- actually Hillsdale was here earlier but had to leave beforehand -- I don't know if the Commission is aware of this, but you know we have had this situation before, their community, their constituents are kind of up in

arms about the MRI issue. There has been legislation introduced. Our preference is to go through this process to show that we are on top of it.
I understand that you have a lot on your work plan. And I appreciate Larry's offer. We would like to make that as easy as possible in terms of, you know, the charge would be to look at the proposed language we have submitted, use a liaison so that we are not using a lot of departmental resources, and, you know, trying to ease your workload a little bit. But with the legislative pressure and the pressure from our hospitals, I would request that if it's possible to place it on the agenda with the understanding that you can't move forward until there is agreement of the Commission, we would be very much obliged.

MS.TURNER-BAILEY: Okay, I understand that. Barbara Jackson?

MS.JACKSON: We just wanted to say Economic Alliance would be happy to work with them on this.

MS.TURNER-BAILEY: Thank you. So is your motion to put the MRI on the agenda -- on the work plan and on the next agenda? Okay, and it was supported by Commissioner Goldman. Any further discussion?

MR.HORWITZ: Madam Chairperson, just to determine the hospital thing. I would urge that the Commission decide you are going to have an advisory committee, authorize the chairperson to solidify the charge, because then we can at least begin the process of sending out notice and recruiting people to serve on it.
We have new rules now. The first advisory committee has different composition than the old one. We can at least begin that. If you wait until March before you even do the two preliminary things I'm talking about, you are never going to move forward on this for many months. I would suggest that we --

MS.TURNER-BAILEY: I wouldn't say never. We will do it in June, right?

MR.HORWITZ: Okay. It's going to take a while to put it together.

MS.HAGENOW: It clearly was one of the charges that came out of the legislature. And one of the things that I think will continue to happen is we will be circumvented in other means the longer we keep having all these issues. Kind of come back to what Sandler said in the beginning, maybe we need to schedule an additional meeting in this year because we are dealing with such big controversial issues that have far ranging --

MS.TURNER-BAILEY: Yeah, I don't disagree with that.

MS.HAGENOW: So time line, I think I look at the department and say, you know, can you do that? But if we put it to advisory and make a chair, does that take the load off and we can go ahead and get that started?

MS.ROGERS: The department is still staffing those advisory groups as well. I guess this Commission just needs to decide which standards you want us to try and complete. MRT and surgical are two that we did testimony on this summer, and unfortunately we are still trying to work on those. I don't have a preference either way, but I guess you as the Commission need to decide which standards are going to take priority for us to work on.

MS.TURNER-BAILEY: Let me let Raj make her comment, even though I don't know if this was supposed to be-

MS.WIENER: This is on the work plan, madam chair. I'm Raj Wiener, and I would like to just comment on the work plan that you are proposing today. In light of the discussions that have happened earlier today, and I didn't follow any of the work that the TAC group was doing or the ad hoc, but I know that they were trying to get up against deadlines and move things through in a hurry. The issue on beds has come and gone before and it does take up a lot of time. But I do think that before you vote to just create an advisory group to get off and start working on this that you need to look at some specific language and that you approve that as the charge to this group at the March meeting as opposed to setting things in motion just kind of loose flowing conversations, that e-mail, the way some of the other stuff happened before. It's just not. I think it would be healthier to have the department draft up the charge, bring it back to the Commission at the March meeting, then take a close look at it and approve it and start the work from there going forward. And I would recommend we just wait until then. Thank you.

MS.TURNER-BAILEY: Thank you. Any questions? Commissioner Hagenow?

MS.HAGENOW: I'm speaking on priority, I guess, to Brenda's question. I think there are issues out there in the clinical and the field, whether that's lithotripsy, MRI or some of those, we probably could prioritize them in terms of -- maybe you even as a team could tell us which ones are receiving the most pressure and time lines, surgical services or -- and then there's these big global issues that change the rest of the world for a long time, and those you don't want to rush because you do something really, really stupid when do you it. But there should be a process moving us to someplace. So I think doing a priority on all those litany of things that are pretty large that we are -- our worksheet is getting so long, and yet, what are we going to finish and which ones are we going to finish when by the demand that we are receiving from the world.

MS.TURNER-BAILEY: Certainly if the Commission feels it is necessary, we could and possibly should look at adding, look at adding a meeting sometime between March and June that would allow us to handle some of these issues that are kind of hanging out there. That way we could do what was suggested relative to a tight charge on exceptions to the bed need, deal with that at the March issue and then get the SAC, the Standard Advisory Committee together following that meeting and follow up on those issues at the two subsequent meetings, whether that would be in April, May, whatever that would be. And we also have a June meeting to deal with that. So if the Commission thinks that we should do that, if that makes sense, I will work with the department to get that set up. And then we don't have to try to squeeze everything on the March agenda. Commissioner Breon?

MR.BREON: I think also, which might be useful, why don't we take some of these issues that we can actually close and get those closed. We always put the big issue up front and it takes up three-quarters of the day. Maybe that's the usual way of doing things, but it might be an idea to try to look at some of those things that may not take that much discussion and actually close them. Because I can see us talking about beds for a long time. Just a suggestion.

MS.TURNER-BAILEY: Commissioner Hagenow, would you like to clarify your motion?

MS.HAGENOW: Well, to create a charter for these exceptions to the bed need. And I guess given our schedule, I would say in the time line of bring the proposed charge to the next, to the March meeting. And then put on the work plan the MRI and actually have it in the March meeting. And perhaps I should add a third thing. I think we should add the extra meeting now so that we can actually close things.

MS.TURNER-BAILEY: Okay, so we will agree to add a meeting in between March and June. We will need to get some dates about where we can get rooms and things like that. And certainly the request that all the Commissioners make all the time, which is to get it done as soon as possible so we can all get our schedules together I think goes without saying. We will send out the e-mails very soon about when those dates might be. And there was a support. Commissioner Goldman, do you support the motion?

MR.GOLDMAN: Yes.

MS.TURNER-BAILEY: Okay, any further discussion on the work plan? All those in favor raise your hand. Eight affirmative. That's unanimous according to where we are right now. Okay, I know we have a couple of Commissioners that need to leave. I'm going to take the public comment cards and then I'm going to ask those who have presentations to get ready. Okay, Maxine Bergman?

MS.BERGMAN: Good afternoon. I asked to speak to the Commission today in regards to bed need. I don't know if I want to open another can of worms after today. But my response is in regards to nursing home bed needs. Currently the bed need is calculated by county, and I want to give an example of our facility of how that calculation hurts us. Our facility is located in Douglas, Michigan. We are in Allegan County, and Allegan County has an excess of 91 nursing beds. We are 13 miles from Holland, Michigan, which is in Ottawa County, and Ottawa has a need for 78 nursing beds.
We have served the Holland area for a long time, and if the Commission would give us some consideration to change how the nursing home beds are calculated, it would give us an opportunity to apply for some of those needed beds. In the year 2003 we had 112 inquiries from the Holland area. 85 percent came from the Holland Community Hospital. Of those 112, we admitted 43. 32 went home or to other facilities, and 37 was declined because we did not have an available bed. This week we had three empty beds that are now being filled with

female occupants. Last week we turned away five male inquiries because our bedrooms were shared by a common bathroom so we needed to have the same sex.
We have 30 beds available in our facility, and the beds are available because we can't compete with the Holland area in regards to assisted living. These are 30 beds in 30 private rooms that we would be very glad to offer to Medicaid recipients. And I think being able to offer a private room to Medicaid recipients is one of the best things we can do. People live alone all their lives, and then when they need our services we expect them to become a compatible roommate with a stranger.
So we are asking that the Commission would give some consideration to nursing homes such as ours where the area served crosses county lines and maybe take a look at that where we could apply for some of those beds and -- you know, the alternative to this is that another Michigan operator has already applied for 77 of those beds, and that's going to create another hardship for the facilities that's in our areas. We are already competing for residents and staff.
So we would like for you to take that into consideration. We would like to offer our assistance in whatever we can do to assist you. And if anyone has any questions, maybe I could answer them for you.

MS.TURNER-BAILEY: Are there any questions? Thank you. Pat Anderson?

MS.ANDERSON: Good afternoon. My name is Pat Anderson. I'm with the Health Care Association of Michigan. Actually, I was trying to get on your work plan. Not that you don't have enough to do, but what we are asking is we would like to be able to -- we represent the nursing homes across the state. And I don't think I can solve the lady's issue that she just brought up, but it would help us, and she was saying single occupancy rooms. What I would like to do is be able to have on the work plan for the Commission that we could bring probably to the March meeting or shortly thereafter an idea where we would set up a new model of nursing facilities that would allow facilities to replace the existing facilities. We are not looking at extending the bed need or the number of beds throughout the state, but being able to replace the aged facilities. Facilities in Michigan are about 30 years old. But to do that, we would need a few changes to the CON standards. One of them we are looking at is the possibility of changing the three-mile rule within the urban areas. Also to change the maximum square footage that is allowed in the construction of a facility. And also the possibility of facilities being able to take a large facility, building one small one new and splitting it down into smaller facilities. Looking at more of single occupancy rooms.
So we would like to know if we could get a group to be able to be on the work plan for that in changing the nursing home standards.

MS.TURNER-BAILEY: Any comments or questions relative to that issue? Any questions?

MS.ANDERSON: Thank you.

MS.TURNER-BAILEY: Okay, thank you. Larry Horwitz?

MR.HORWITZ: This will be very quick. This question is as much for the department as for anyone else. It has come to our attention that issues have developed where there are bed needs, bed shortages that get identified in a given sub-area. In this particular instance it was nursing homes on the western side of the state, at which that came about because of recalculations by the department of inventory. There was one application and nobody else knew about it.
Would it not be appropriate that whenever there is a bed shortage identified because of a change in the inventory that the department publicize that so everybody has an equal opportunity to come in and apply? Not just the ones who happen to be lucky enough to hear about it. Larry, do you know what I'm talking about?

MR.HORVATH: The only response is we are aware of that situation. The past practice ever since the program has been in existence, there is only three times in a year that you can get beds, and the onerous was on the actual applicants to know that in February, June and October that you should be checking the inventory prior to that.
However, with that said, the department is looking at avenues to use the web so you can check the inventory 24 hours a day, seven days a week.
As far as notification, we will also talk about that later today that we are creating a web mechanism that will provide notifications for changes.

MR.HORWITZ: What I' m concerned about is a situation that developed a few years ago.As of the window date of February 1 there was no need. An application was received, and the need materialized ten to 20 days later. So that it seemed to me that goes totally contrary to the whole spirit of the Oshenbacher (phonetic) doctrine in comparative review.

MR.HORVATH: But that occurs because of a licensing function. We have no control when somebody de-licenses beds. We did not recalculate the bed need. What has occurred is maybe after the window date closes we are notified by licensing that beds are de-licensed and, therefore, a need is created. So the next window date for those beds will be the next window.

MR.HORWITZ: But the way it happened was it was retroactive to the past window date. The need -- yes, sir, I know about the specific hospital.

MR.HORVATH: But I am just telling you that is not the way we apply that at this point in time. It is the bed inventory at the time of the window date.

MR.HORWITZ: So it will not be any further the bed inventory as of sometime between that window date and the next window date.

MR.HORVATH: If you are in a comparative review, no.

MR.HORWITZ: Do you have that in writing somewhere? This is a new approach by the department. Is that written down somewhere so that everyone would know about this?

MR.HORVATH: I guess I' m not....

MR.HORWITZ: Up until now, if I applied for beds on February 1 and there was no need, and the need then materialized by a licensing action that then occurred some days later --

MR.HORVATH: I would be more than happy to discuss this and other opportunities. I' m not sure that- this is a technical process and I' m not sure it is a policy discussion for the Commission. But I would be happy to discuss that.

MR.HORWITZ: Fine. Thank you very much.

MS.TURNER-BAILEY: Dale Steiger?

MR.STEIGER: Just in the spirit of openness, I would like to indicate that the TAC, once again, will meet this afternoon for a few minutes at the conclusion of this meeting to try and get ourselves organized to proceed with our charge. And we would certainly like to invite representatives from the department to take part in this. So we will be meeting in the back of the room somewhere.

MS.TURNER-BAILEY: Thank you. Okay, we have a couple of presentations that we would like to see. One is on the CON database. Jed Henrie. And also one on the listserv, which would be Carol Halsey. And you can come up and get started with those. In the meantime, I think we have covered a lot of those updated issues as we went through the work plan, so we don' t necessarily have to go back through these. Is there anything particular on the PA 619 update that we need to go through today?

MS.ROGERS: No. Hopefully you can hear me? I will try to speak loud enough. On that list in the back that I mentioned earlier on the PA 619 item, just please, you know, take a look at that so you are aware of what items you still have to address. And then it is more for your information and hopefully as a guidance tool as we go down this road. Also, just to cover new medical technology really quick, there is nothing new to report there.

MS.TURNER-BAILEY: Okay, so the presentations are the last thing. As a reminder, our next meeting is March 9. We will add to the agenda sometimes between March and June. I want to get through every other piece of the agenda so we don' t have to come back.

We have added a new agenda item which looks like we might not get to that today, which is a compliance report. That's something we are going to start doing regularly. That gives us an opportunity to hear the department's report on their compliance actions.
We are also considering adding something which I will just call a legislative update so that we are all understanding what's going on in the legislature for issues related to CON, and that gives us an opportunity to sort of, in case we don't read the (inaudible) every day, we know what's going on relative to the legislature.
Okay, Jed is ready.
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(Presentations given and not recorded.)
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We are quickly going to do the compliance report. I don't think we have a quorum to adjourn. I will just adjourn myself.

MR.HART: Madam Chairman, we have our first compliance report that the department is going to start to issue every three months. The one that you have in front of you here outlines two entities that were found in violation of the Certificates of Need and what had happened as the department took compliance activity. This is in response to the more clear direction that is coming from Public Act 619 about taking some act of compliance activity.
In a nutshell these two entities were found to be operating without a Certificate of Need. The department met with these people, and we talked about what type of activity needed to go forth for them to continue providing these services. They immediately stopped providing the service that they had a Certificate of Need clearance to provide, had placed into our hands new applications for Certificates of Need to replace these two pieces of equipment.
In negotiation with this operator the department and the operator agreed that $210,000 in what we were calling charity care would be offered to that community through this operator. This operator was pleased to be able to offer that service to increased access to care for folks that are without the means for some of these services.
So we think this is a pretty good way of doing business. We will be, obviously, more active in the area of compliance and we will be reporting to this Commission on a regular basis which compliance actions we have taken, and hopefully bring a model to this Commission on how we will go about this. I don't believe we will be able to laboriously check every single CON, but we have been doing some talking about some statistical modeling and some sampling-type activities. So as we start to get into the area of compliance, we will be sharing that with the department.
This was our first one, and we wanted to be sure that -- it was part of the settlement agreement, by the way, that this be shared with the Commission. So any kind of compliance activity that the department takes, the Commission will see the report.

MS.TURNER-BAILEY: Thank you. I appreciate that. I have a question. Are these two organizations the same organization? Was there a common ownership?

MR.HART: Yes, there is a common ownership.

MS.TURNER-BAILEY: Any other questions? Yes, Larry?

MR.HORWITZ: In the spirit of the Open Meetings Act, is it possible for the audience to know what covered service and who is the provider?

MR.HART: Sure. The covered service was CT. And the provider was Greater Flint Imaging Center in Park Plaza in Flint.

MR.HORWITZ: And their violation was?

MR.HART: They were operating scanning equipment without a Certificate of Need.

(UNIDENTIFIED SPEAKER): They actually replaced their -- they were approved in '92 and '93 to have CT scanners, but then they went in subsequent years and replaced them without CON review and approval.

MR.HORWITZ: The reason I point that out, under the statute there are rights that (inaudible) purchasers as a result of your compliance action, you need to put that out publicly so people know about it.

MR.HART: Yes, and that's part of what 619 says, Larry, as you know, that the department has to make a report of what's going on here and anyone can, any payors, you know, that would be their own action on something like this. So we are announcing that activity this afternoon.

MR.HORWITZ: Right. But besides someone coming to this meeting, how would some other payor come to know about that? Would this be on the wonderful new web page?

MR.HART: Yes.

MS.TURNER-BAILEY: Are there any further questions? Any comments? I believe I took all cards. As I said, we don't have a quorum to vote on an adjournment, so I'm going to announce that we are adjourning. We will see everybody in 2004. Wish all of you a happy holiday season. Safe travel. We are adjourned.

(Deposition concluded at 4:10 p.m.)